Illinois' Strong Foundations Partnership
The Implementation Plan for the Maternal, Infant and Early Childhood Home Visiting Program

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Introduction to Home Visiting in Illinois

Illinois' system of home visiting programs has developed over the last 30 years. This introduction provides a brief review of the current administrative structure at the state level and information about local home visiting programs to provide context for understanding Illinois' approach to this implementation plan.

Governor Quinn recently established an Office of Early Childhood Development. This office provides overall coordination and policy leadership for the development of an integrated system of early childhood services. The Project Director for the Maternal, Infant and Early Childhood Home Visiting Program (MIECHVP) is based in this office. This person also directs Illinois' "Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment" (EBHV) grant. This is one of 17 such projects across the country funded by the federal Administration for Children and Families. In Illinois, this project is known as "Strong Foundations," while the MIECHVP project is known as the "Strong Foundations Partnership."

Three organizations are primarily responsible for funding home visiting programs in Illinois. The Illinois Department of Human Services (IDHS), which serves as the lead agency for MIECHVP, has provided financial support for 37 Healthy Families America (known in Illinois as Healthy Families Illinois) programs. The Illinois State Board of Education's (ISBE) Division of Early Childhood Education provides financial support for 104 Parents as Teachers programs, one Healthy Families Illinois program and one Nurse-Family Partnership (NFP) program. (This NFP program is also supported by local funds.) The Ounce of Prevention Fund, which operates as a public-private partnership, combines private resources with state funds from the IDHS to operate the Parents Too Soon (PTS) program. PTS, which began in 1982 as a gubernatorial initiative to reduce teen pregnancy, now operates 20 home visiting programs across the state. Nine PTS sites use the Healthy Families America model, nine use the Parents as Teachers model and two use the Nurse-Family Partnership model. The Ounce of Prevention Fund acts as an intermediary for the state, using public funds for program operations, and private funds to seed innovation and program development. IDHS and ISBE also provide financial support to the Ounce of Prevention Fund to operate the Illinois Birth To Three Institute, which trains local staff from all state-funded home visiting programs. ISBE also provides financial support to the Ounce of Prevention Fund to operate the Parents as Teachers State Office. Responsibility for managing grant awards for local program operations remains with the funding agency. In addition, the Administration for Children and Families of the U.S. Department of Health and Human Services (HHS) provides federal funding for a total of 30 Early Head Start programs in Illinois, of which 28 currently provide home visitation services. This information is summarized in Table 1.

Table 1 Number of Evidence-Based Home Visiting Programs by Funding Source: Illinois, 2011				
	Home Visiting Program Model			
Funding Source	EHS	HFI	NFP	PAT
IDHS		37		
ISBE		1	1	104
Ounce of Prevention Fund		9	2	9
USDHHS	28			
Total	28	47	3	113

These organizations, along with Voices for Illinois Children, a leading child advocacy organization, the Illinois Department of Children and Family Services (Illinois' child welfare agency), the Illinois Department of Healthcare and Family Services (which operates the All Kids and FamilyCare programs[1]) and the Illinois Coalition Against Domestic Violence comprise the Strong Foundations Partnership.

The Strong Foundations Partnership supports and is supported by the Home Visiting Task Force. The HVTF, led by its Executive Committee, serves as the convening, policy-setting, and decision-making body for the Strong Foundations Partnership. The Task Force is currently co-chaired by the President of the Ounce of Prevention Fund and the Vice President of Voices for Illinois Children. (The Task Force has more than 100 active members; the organizations they represent are listed in Section 6.) The members of the Strong Foundations Partnership, along with faculty from the Chapin Hall Center for Children at the University of Chicago, comprise the Home Visiting Task Force's Executive Committee. Hereinafter, the term "Executive Committee" refers to the joint actions or decisions of its members working in collaboration.

The Task Force is a standing committee of Illinois' Early Learning Council. The council was created by state statute in 2003 and also serves as Illinois' State Advisory Council on Early Childhood Education and Care authorized by the Head Start Act.

Three strategies comprise Illinois' proposed approach to the implementation of MIECHVP:

1. The expansion or enhancement of one or more of five evidence-based models of home visiting;
2. Ensuring that the home visiting program is effectively connected to community-based organizations and services required to achieve the benchmarks; and
3. The further development and strengthening of a statewide system of evidence-based and innovative approaches to home visiting and the state and local infrastructure necessary to support effective service delivery. This will include the development and testing of a system of universal screening and coordinated intake and the enhancement of an early childhood collaborative in each target community.

[1] All Kids combines Medicaid, the State Children's Health Insurance Program and state funds to provide health insurance coverage for children. For additional information, see IDHFS' web site, www.allkids.com. FamilyCare provides healthcare coverage to parents living with their children 18 years old or younger. FamilyCare also covers relatives who are caring for children in place of their parents. For more information, see IDHFS' web site, www.familycareillinois.com

The Executive Committee has selected the following communities as target areas for the initial round of MIECHVP funding. Our proposed strategy is to maximize the impact of the MIECHV funding by building on multiple home visiting programs in each target community – expanding service capacity and transforming the existing programs into a more cohesive community collaborative. The target areas and the model(s) we will build on in each one are listed below. (Refer to the maps in Appendix 1.)

- The Englewood, West Englewood and Greater Grand Crossing Community Areas in the city of Chicago will expand Early Head Start, Healthy Families Illinois and Parents As Teachers. A new Nurse-Family Partnership Program, supported with state and private funds, will begin to serve families in June 2011.

- The city of Elgin will expand four home visiting programs, including Early Head Start, Healthy Families Illinois, the Nurse-Family Partnership and Parents as Teachers.

- Macon County will expand three home visiting programs, including Early Head Start, Healthy Families Illinois and Parents as Teachers.

Section 1: Identification of the State's at-risk target communities

In this section, the process for identifying the target communities for Illinois' MIECHV program is described. The three target communities are also described, with the key elements of need and resources noted for each, and the plan for expanding services using new federal funds.

Selection of Target Communities. The needs assessment identified 30 communities in three geographic clusters of ten communities each: ten Community Areas in the city of Chicago; ten townships or cities in suburban Cook County and the surrounding "collar counties;" and ten counties in the balance of the state. These communities were further analyzed in two ways. First, the five most populous communities from the city of Chicago and the "collar counties" were selected for further analysis. This step was taken to ensure that the target areas would have a sufficient number of births to support and efficiently operate one or more home visiting programs. Second, since many of the downstate counties identified by the original needs assessment were rural communities with small annual numbers of births, the counties in the balance of the state were reconsidered and six cities with high need indicators were selected for further consideration, along with the two most populous counties from the original needs assessment. Thus, 18 candidate communities remained for final selection: five Community Areas in the city of Chicago; five townships in suburban Cook County or the "collar counties," six downstate cities and two downstate counties.

Additional Data. In a second phase of the needs assessment, additional data on demographic characteristics of each area's population, as well as existing home visiting programs and their total and current capacity were gathered for consideration. These characteristics were weighed in the final selection process.

Qualitative Semi-final Selection Criteria. The Executive Committee of the Home Visiting Task Force developed a set of criteria for selection of the semi-final target areas. These criteria were

presented to, and approved by, the full Task Force prior to the selection of semi-finalists. The criteria include:

- Statewide representation, balanced with the current distribution of home visiting program funds;[2]
- Representation of Latino and English Language Learning populations;
- Existing community collaborations and home visiting program capacity; and
- Capacity Agencies that can identify and serve the homeless population.

Semi-Finalists. The 18 target areas were narrowed to nine semi-finalists by the Executive Committee of the Home Visiting Task Force through examination of all of the data collected through both phases of the needs assessment and application of the qualitative final selection criteria.

Finalists. The nine semi-finalist communities were invited to make a presentation to a selection committee comprised of Home Visiting Task Force Executive Committee members, other state agency staff and advocates. (The other nine communities were also invited to participate on a first-come, first served basis if any of the nine semi-finalists elected not to make a presentation. However, all nine semi-finalists elected to present.)

The nine communities that made presentations to the selection committees were:

1. Englewood, West Englewood and Greater Grand Crossing Community Areas in the city of Chicago;

2. The East Garfield Park and North Lawndale Community Areas in the city of Chicago;

3. Waukegan Township in Lake County;

4. Cicero Township in Cook County;

5. Thornton Township in Cook County;

6. The City of Elgin in Kane County;

7. The City of Rockford in Winnebago County;

8. Macon County; and

9. Vermilion County

The organizations that represented each community are listed in Table 2.

[2] The needs assessment found that 21% of program slots serve families in Chicago; 18% in the townships; and 61% in the balance of the state. Illinois vital statistics show 25.7% of births occur in Chicago; 42.3% in suburban Cook and the collar counties; and 32% in the balance of the state. Home visiting program resources are disproportionately allocated to downstate Illinois.)

Table 2 Community Presentation Participants	
Community	Presentation Panel Organizations
Englewood, West Englewood and Greater Grand Crossing	Children's Home and Aid Society Community Organizing and Family Issues Family Focus Englewood Henry Booth House
East Garfield Park and North Lawndale	Community Organizing and Family Issues Family Focus Lawndale Healthy Families Chicago Lawndale Christian Health Center Marillac Social Services Project LAUNCH
Waukegan Township	Child Serv Early Head Start / YMCA Lake County Health Department One Hope United United Way of Lake County
Cicero Township	Children's Center of Cicero-Berwyn Pillars Family Focus
Thornton Township	APAC/DPAC Austin Peoples Action Center Easter Seals of Metropolitan Chicago ECHO Healthy Families Illinois / DPAC Thornton Township
City of Elgin	Family Focus Aurora Greater Elgin Family Care Center Kane County Health Department School District U-46 Parents as Teachers Visiting Nurses Association of Fox Valley
City of Rockford	City of Rockford Easter Seals – Rockford Region Rockford Public School District #205 Winnebago County Health Department
Macon County	Baby Talk Community Foundation of Decatur, Macon County Decatur Education Coalition Macon County Health Department Pershing Early Learning Center
Vermilion County	Center for Children's Services Danville School District #118 East Central Illinois Community Action Agency Family Education and Support Services

The Executive Committee met to review the presentations and selected the following communities:

Englewood, West Englewood and Greater Grand Crossing.

Need. These three communities on the south side of Chicago were identified in the original MIECHVP needs assessment. In brief, these three communities are impoverished: between one in three and one in five families in these three communities had incomes below the federal poverty standard in 2009 and the proportion of single-parent household was similar. More than 85 percent of the births in these communities are financed through Illinois' Medicaid program. Between 16 and 17 percent of the newborns in 2008 had low birth weights, more than 90 percent of all infants were born to single mothers and between 10 and 12 percent of all infants were born to a mother who was less than 17-years-of-age. Ninety-seven percent of the community's population is African-American.

Resources. While Englewood, West Englewood, and Greater Grand Crossing have many needs and risk factors, they also have a number of strengths. There is a sense of community among residents of these communities. Many families are long-time residents of these communities, have pride in their homes and work to better the community. Many grandparents are involved in their grandchildren's lives and provide a variety of support to the families. Some are raising their grandchildren. Many grandparents are active in early learning activities. These communities are experiencing revitalization and economic development. In Englewood, there are new buildings and commercial enterprises in the area around 63rd Street and Ashland Avenue. The area offers several tax-increment financing (TIF) districts and the area surrounding Halsted and 63rd Streets is the focus of redevelopment into "Englewood Center" with construction of new buildings at Kennedy-King College. The churches in the community continue to be sources of strength and support for many families. Many provide assistance to low-income families including food pantries, programs for youth and housing developments for the elderly. Local pastors have an active council that is engaged in issues of the community. Public transportation availability in Englewood, West Englewood, and Greater Grand Crossing enables parents and families to travel to work, early childhood centers, and schools.

Community groups have formed to address concerns. Teamwork Englewood, a local community development organization, has fostered many new initiatives and encouraged community collaboration. The Englewood Safety Networks Coalition is a network of community agencies that provide comprehensive and coordinated violence prevention activities for community youth. The Chicago Public Schools has invested in improving the schools in the community with support of after-school programs and the development of Community Action Councils. There are several high-performing high schools in the communities, including Lindblom Math and Science Academy, a selective enrollment high school, and Urban Prep. The CPS Office of Special Services works closely with Child and Family Connections to transition children into kindergarten and ensure continuity of services. City-Colleges (Kennedy-King College) represents the premier community learning institution and destination for college-ready/career-ready youth and adults in the community. Kennedy King College provides education and training opportunities to parents, including GED instruction.

The availability of specialized medical services, including pediatric services, is a strength. Access Community Health Network has engaged specialized pediatricians from University of Chicago to provide services at its Grand Boulevard location. St. Bernard Hospital, located in Englewood, provides a variety of services to the community and is an important source of prenatal and pediatric healthcare. At its Englewood Neighborhood Health Clinic, the Chicago Department of Public Health provides a full range of primary health services to improve the health and lives of community families. Services include case management, public health nursing, health education, prenatal and pediatric care, family planning, mental health services, parenting education for males, and WIC services. Beloved Community Services offers pediatric medical services and a variety of other services.

The Illinois Maternal and Child Health Coalition, along with other partners such as the Illinois Department of Human Services, the Illinois Department of Healthcare and Family Services, the March of Dimes and SIDS of Illinois, worked together on the "Closing the Gap on Infant Mortality" , a federally-funded initiative to reduce the gap in infant mortality between African American and Caucasian babies. The group developed and implemented a peer education curriculum and training, marketing campaign, and outreach strategies to reach women in the Englewood and Austin communities. "Closing the Gap on Infant Mortality"[3] eventually became a special project at IMCHC, and has since changed to become the "Campaign to Save Our Babies." The group has recently become revitalized, and will focus its work on the Englewood and West Englewood communities. The Englewood and West Englewood Community Areas are also targeted by the Chicago Department of Public Health's Greater Englewood Healthy Start initiative.

Six agencies operate eight home visiting programs in and around these three community areas, including:

- Henry Booth House, which operates a Healthy Families Illinois (HFI) program that serves an average of 80 clients per month. Two doulas in the HFI program serve 130 parents each year.

- Family Focus Englewood operates HFI and Parents as Teachers programs. The HFI program targets first time teen parents who are 13-19 years of age, living in Englewood, who deliver at St. Bernard Hospital. The PAT program targets parents of children 0-3 years old who are over 19 years old upon enrollment. Family Focus serves 65 participants in the target communities through HFI and 75 participants in the target communities through PAT.[4]

- True to Life Foundation operates a Parents as Teachers, housed in Englewood area public schools.

- Mercy Health Center is implementing a new Nurse Family Partnership program through Parents Too Soon.

[3] Grant number 1 U19 MC03177-01-00

[4] The HFI services are provided as a part of Parents Too Soon; the PAT services are supported by the Chicago Public Schools with Early Childhood Block Grant funds from ISBE.

- Children's Home + Aid operates Early Head Start and Parents as Teachers programs with a capacity of 24 slots.

- Childserv operates a Parents as Teachers program with a capacity of 140 slots.

In addition, the Chicago Department of Public Health's public health nurses provide in-home case management and nursing services as a part of the state's and city's Chicago Family Case Management and High Risk Infant Follow-up programs. The nurses' services include assessment, monitoring and follow-up guidance, counseling, physical assessment of mothers and infants. Nurses use the Edinburgh Postnatal Depression Scale and the Denver Developmental Screening Tools to assist in their assessment of mothers and infants. The caseload for the home visiting programs in 2010 was 9733 which is 75% of the targeted capacity caseload. Caseloads for Public Health Nurses are 155 active cases per PHN in the CFCM program, although some case managers handle as many as 250 cases per month. In 2010, CDPH received 3,439 infant and 254 maternal high risk referrals in the Adverse Pregnancy Outcomes Reporting System program. (These in-home services do not follow one of the evidence-based home visiting models selected for MIECHVP.)

The need for early childhood services in Englewood, West Englewood, and Greater Grand Crossing significantly exceeds the current capacity of programs in the area. According to the Illinois Early Childhood Asset Map, there are 16,514 children under the age of 5 living in the target communities. Of these, 15,492 live below 200% of the poverty level, and 6,774 live below 100% of the poverty level. The existing early childhood capacity in the communities, including Preschool for All, Head Start, Early Head Start, licensed and license-exempt child care centers, family child care homes and home visiting programs, can serve only 6,227 children (38% of the community's children under 5).

The need for home visiting and other intensive programs to serve the highest-risk infants and children is even greater. There are 4,360 children ages 0-3 who live at or below 100% of the federal poverty line, dramatically exceeding the community's current capacity to serve high risk pregnant women and young children. The existing home visiting capacity of 356 slots and Early Head Start capacity of 111 slots can serve only 11% of the community's highest-risk children.

The impact of this gap in services for the community's infants and families can be seen in the community's poor maternal and child health outcomes. The communities have very high rates of low birth weight, infant mortality, and premature births, and a smaller percentage of women in the target communities receive prenatal care in their first trimester, compared to Chicago as a whole. The communities' rates of child abuse and neglect are twice that of Chicago on average, indicating a strong unmet need for parent education and support. The target communities have some of the highest rates of crime and domestic violence in the city of Chicago, and only 18% of adults in the community have completed some type of postsecondary education.

Existing mechanisms for screening, identification and referral. The existing home visiting programs have a variety of mechanisms for identifying eligible families. Family Focus receives referrals from: St. Bernard Hospital, where a positive screen has resulted; from the Department

of Obstetric and Gynecology prenatal clinics, when mothers in the last trimester are identified as eligible for HFI; from other Illinois Healthy Families sites; and self-referrals through Englewood community high schools. Mothers are screened and identified as eligible for HFI using the Kempe assessment and the Edinburg Maternal Depression Screening. Children are screened with the Ages and Stages Questionnaire (ASQ).

Henry Booth House receives referrals from the city and state referral systems such and the Cornerstone system. Also referrals come from the partner Head Start sites, agencies that it has linkages with, such as CEDA, Sassy, Metro South Hospital, Cook County WIC Department or SGA and Chicago Charter Schools. Major outreach and recruitment for the HFI program comes from the Case management programs and WIC program at Henry Booth House. HFI FSWs also outreach at the surrounding DHS office and clinics. Henry Booth House screens using ASQ, Kempe checklist, and Edinburg Maternal Depression Screening.

Children's Home + Aid identifies children and families who are eligible for Early Head Start through referral linkages and collaborating agencies that provide a range of services beyond early childhood education. To recruit as many age- and income-eligible infants and toddlers as possible from the community, Children's Home + Aid produces flyers, brochures, and promotional materials that include an explicit message about our services to children with disabilities. Community Partnership Agreements with LEAs and local health clinics in each community promote recruitment of pregnant women, infants and toddlers that are or might be at-risk of developmental delay or disability. Other specific recruitment activities include twice yearly outreach letters to relevant community partners, recruitment fairs, hosting community activities, and attending neighborhood functions. Children's Home + Aid screens using the ASQ and the Early Head Start eligibility checklist.

Referral Resources. There are a number of agencies that offer the ancillary services that home visiting program participants may need. The providers of these services include:

1) Mental health counseling: Ada S. McKinley Community Services; Beacon Therapeutic Diagnostic and Treatment Center; Beatrice Caffrey Youth Services; Chicago Department of Public Health (adult mental health, substance abuse interventions); Children's Home + Aid Society; Metropolitan Family Services; the Community Mental Health Services of Resurrection Health Care; Family Focus (mental health services for CEV); Henry Booth House; and the YMCA of Metropolitan Chicago (for treatment of sexual abuse).

2) Substance abuse treatment providers: Family Guidance Center of Chicago; Henry Booth House; Human Resources Development Institute; and the Women's Treatment Center (an active member of the Home Visiting Task Force).

3) Domestic violence: Clara's House

4) Homelessness: Chicago Department of Family and Support Services; Heartland Alliance (offers homelessness services housed in Family Focus Englewood); and New Moms.

5) Family Case Management Services: Chicago Department of Public Health; Access Community Health Network; and Henry Booth House

6) WIC: Catholic Charities; Henry Booth House

7) Child and Family Connections (Early Intervention Services): Easter Seals; LaRabida Children's Hospital

8) Primary Medical Care: Access Community Health Network; Beloved Community Family Wellness Center; Chicago Department of Public Health; and Mercy Family Health Center.

Plan for Coordination. The community collaboration for MIECHVP has proposed a system of universal screening and coordinated intake for early childhood services. Participating agencies and outreach organizations will use a universal screening form to identify clients who may be eligible for home visiting services. The home visiting programs will continue to use their existing screening tools, as required by the evidence-based model. The screening and assessment tools used for MIECHP (e.g., the Edinburgh Perinatal Depressions Screening questionnaire) will be used to trigger referrals to other community agencies. Further analysis of the screening questionnaires will be conducted to identify items that can be used to "trigger" referrals for specific services.

Integration of Home Visiting and Other Services. The organizations that participated in developing the community's presentation have proposed a governance structure. It is comprised of a Steering Committee and four standing committees. The standing committees are: Training and Outreach; Community and Consumer Engagement; Program Evaluation; and Service Delivery. The Steering Committee is comprised of the co-chairs of the standing committees and other community stakeholders.

The City of Elgin

The city of Elgin is located along the Fox River in Kane County, approximately 38 miles northwest of Chicago. It has a total population of 102,590 residents, based on the 2005-2009 American Community Survey. There were about 23,500 families in 2009; nearly nine percent of them lived on incomes below the federal poverty standard. Forty percent of the population is Latino. The city has about 9,000 children under six years of age.

Strengths. Elgin has many strengths relating not only to children's health, but also the health of adults. The *Activate Elgin* initiative is working to reduce the problem of obesity in the city, particularly in children. It consists of community partners, including hospitals, the school district, city of Elgin, YMCA, United Way, the library and other agencies which collaborate on the problem and work toward the common goal of reducing obesity in the area. There is a strong faith-based support community in Elgin, including the Provena Faith-Health Partnership, African-American Ministerial Alliance, soup kitchens, and the PADS network.

A key community partner, the Elgin U-46 School District offers many assets for young children and early learning. An incremental school readiness program is in place. The District's graduation rate at the high school level reveals strength. At 88.5% in 2008, it was higher than the average for the state of Illinois. The District has an aggressive school improvement plan and is dedicated to bringing students the best education possible. Another group dedicated to helping

Elgin students is *Project Access*, which helps students who are homeless and give them the support and resources they need to succeed not only at school, but also at home. They help parents with filling out forms and acquiring medical, dental, and vision care for their family.

The United Way of Elgin has a strong community presence, offering services and coordinating programs designed to help residents of Elgin and the surrounding community. It also maintains the Kane County Guide to Community Services. This on-line information and referral service allows people to search for social, health, or human service providers in the county by using a simple search tool.

Elgin has other unique assets. Members of the Elgin Circle of Wise Women empower residents to lower infant mortality rates among African-American women; the Elgin YWCA provides support and outreach to the Asian and Laotian communities through programs like the YWCA Southeast Asian Youth program and the YWCA Family Literacy program. The Grand Victoria Foundation (supported by proceeds from a riverboat casino) forms partnerships with organizations that strengthen educational opportunities for children and adults, boost the economic vitality of neighborhoods, cities, and regions, and restore and preserve the health of our environment. The Gail Borden Public Library provides a community gathering spot for families with young children through reading groups starting at age nine months, to activities for children during school holidays and summer vacation and adults learning English as second language. They celebrate cultural diversity through Black History month and Cinco de Mayo events and month-long displays on cultural diversity and provide a "melting pot" by collaboration with area social services for employment workshops, tax preparation, political forums and New Americana events.

Existing home visiting services. Currently only three Home Visitation Programs exist in Elgin: District U-46 Parents as Teachers, Early Head Start, and the Kane Kares Nurse Family Partnership Program. Capacity is very limited and has decreased over the past three years. The Kane Kares Nurse Family Partnership Program (KKNFP) serves very high risk families with first time low income mothers. The program can serve 36 families. Two-thirds of the current participants are teen-aged mothers; 87 percent are Latino and two-thirds are in school or have less than a high-school education. The Early Head Start program serves low income pregnant mothers and parents of children ages 0-3. The program can serve 50 families. Most (55%) of the parents currently participating in the program are between 20 and 29 years of age; 80 percent are Latino and nearly half (43%) have less than a high-school education. The District U-46 Parents as Teachers program serves high risk pregnant mothers or parents of children ages 0-3. The program can serve 110 families. Most (42%) of the parents who are currently participating in the program are teens; most (61%) are Latino and most (61%) are in school or have less than a high-school education.

Need for expansion. The need for home visiting services in Elgin considerably exceeds the supply. The Illinois Department of Healthcare and Family Services reports 2,099 births in 2009 to women who listed an Elgin zip code and also gave Elgin as their residence. Of these, 1,161 -- 55 percent -- were financed by Medicaid. This suggests that there are about 3,500 Medicaid-eligible children between birth and three years of age in Elgin. Since there are only 186 home visitation slots available, only five percent of families can be served. A more conservative

estimate of unmet need can be derived by applying a recent estimate of risk to the number of Medicaid-eligible births. A study of Family Case Management program participants (nearly all of whom are Medicaid-eligible families with a pregnant woman or an infant) conducted in 2010 by the Kane County Health Department found that 28 percent were determined to be at-risk. Applying this percentage to the 2009 Medicaid-insured births, there are 322 at-risk families with a newborn each year. Assuming that an equal number of at- risk, Medicaid-insured births occur for each of three successive years, a total of 966 at-risk families are in need of home visitation at any given time. By this estimate, only 20 percent of the need is being met by the existing home visitation programs.

Existing mechanisms for screening, identification and referral. Enrollment in home visiting programs is coordinated through the Kane County Home Visitation Committee (HVC), a unique and effective mechanism for coordinating activities among nine home visiting programs in the county. The HVC was organized in 2000. The HVC pooled efforts and resources at the system level. Soon, a centralized referral process was created and implemented utilizing FCM[5] intake appointments with newly expectant mothers as a key access point, since 95 percent of Medicaid-eligible mothers entered the ECS system through FCM. Though the HVC was a county-wide group, the Elgin partners collaborated together on the unique aspects of their community needs and contributed to the effectiveness of the larger group as well.

A voluntary effort from the beginning, the HVC was formed with representation first from the existing Healthy Families, Nurse Family Partnership, and Parents as Teachers programs in Elgin and Aurora. Soon Early Head Start, the Day One Network CFC,[6] FCM, and the High Risk Infant Follow Up[7] program joined with the support of the FCM and TPS[8] programs. The HVC members agreed on a job description for the HVC facilitator and this position was filled through the Kane County Health Department. Eventually, members authored an HVC charter which was signed by member agency executive leaders.

Since the need for home visitation was so great and the resources so few, the HVC's initial goal was to assure that all home visitation programs received adequate referrals to always stay full and to avoid any duplication of services. The HVC created a centralized home visitation referral system in response to this need. At FCM intake interviews, mothers were offered the opportunity to receive home visiting and the FCM case manager obtained consent to make the referral and identified all the risk criteria that had emerged through the intake interview. The referrals were collected by the HVC Facilitator, recorded in a tracking database, and distributed among all the programs according to their eligibility criteria, the mother's residence, and the program capacity.

The HVC referral process mechanisms have evolved and improved over time, changing as often as system changes occurred. Just this year, the HVC revised the referral form in light of the recent reorganization of FCM within the county, reviewed joint policies to prevent duplication,

[5] Family Case Management, a statewide Title V initiative to reduce infant mortality through case management.
[6] Child and Family Connections, the regional intake system for Part C Early Intervention services.
[7] Infants identified through Illinois' Adverse Pregnancy Outcomes Reporting System are offered five home visits by a public health nurse during the first two years of life.
[8] Teen Parent Services, a statewide Title V program to support low-income teen parents.

and committed to a new referral tracking system to document the disposition of referrals. Additional training for the new FCM case managers now employed by the two Elgin community health centers is being planned so that they will have a good grasp of what the home visitation services are like and how they benefit the families. Opportunities to shadow home visitors on a home visit will be offered to further engage the new FCM case managers in the critical process of promoting home visitation. This is especially important for high risk clients who may entertain fears of punitive visits.

Collaborative goals and activities beyond a centralized referral process were implemented as the Home Visit Collaborative developed: 1) use of a common referral form for all HV programs; 2) unified home visitation marketing/promotion materials were created in addition to materials produced by each program; 3) shared workforce development trainings were offered to all HV program staff based on HVC members input (Attachment 15, training topics); 4) active participation in AOK assessment, strategic plans, and initiatives; 5) specific HVC action plans were developed to address ECS/AOK goals and objectives; 6) participation in the County Community Health Assessment; followed by development/implementation of specific HVC action plans to address identified needs.

Referral Resources. Elgin has several providers of mental health services, including Ecker Center, Family Service Center of Greater Elgin, Catholic Charities, Kairos Family Center, Larkin Family Counseling Center, Lutheran Child and Family Services, Northwest Behavioral Resources and Sherwood Behavioral Health. The Family Service Center and Larkin Family Counseling also offer substance abuse treatment. Emergency mental health response for Medicaid-eligible clients is available, but access for low income, non-Medicaid eligible postpartum mothers is limited. Matching need with MH/SA capacity has been a longstanding challenge for Elgin.

Workforce development and ECS/AOK initiatives have increased capacity among home visitors and other ECS professionals to screen for maternal depression and infant social-emotional health. The AOK Network's partnership with the IDHFS' ABCD[9] project improved screening rates by collaborating with Kindergarten Round ups to promote 0-3 screenings and by encouraging primary care providers to use objective screening tools in their practices. AOK representation on the Kane County Mental Health Awareness Committee assures that MCH mental health needs and activities are carried out, such as ―*Say It Out Loud*[10] and active participation with the Illinois Children's Mental Health Partnership.

One of the HVC members serves on the board of the Community Crisis Center, which provides domestic violence services in Elgin and northern Kane County. Workforce training on domestic violence screening --and intervention upon disclosure—has reached home visitors and other

[9] Assuring Better Child Development, a project of the National Academy of State Health Policy, supported by a grant from the Commonwealth Fund.

[10] A public information campaign of the Illinois Department of Human Services and the Illinois Children's Mental Health Partnership to reduce the stigma associated with mental illness.

early childhood workers. Intimate violence studies have been conducted in collaboration with two HVC partners.[11]

Health services for low income pregnant women, infants, and young children are widely available, regardless of insurance eligibility, since two community health centers provide care. Dental care is offered by one community health center and the Well Child Center in Elgin. In addition, a Kane County Dental Coalition coordinates the delivery of dental sealants in the schools by several sealant providers and requires referral and linkage for children who need treatment. Nutrition services through WIC are offered by the Well Child Center and are co-located with the community health centers and the FCM programs.

The Elgin ECS/AOK enjoys the active and proactive partnership of the Day One Network, the CFC for Kane County. CFC representatives not only attend meetings, but engage in many Elgin community events. The CFC and DSCC[12] are regular participants in the Perinatal Committee meetings and interventions. The High Risk Infant Follow-Up Program, along with all home visiting programs, tracks Early Intervention referrals in collaboration with the CFC.

Plan for coordination. The existing mechanism for coordinating intake among the community's home visiting programs will continue. The HVC members have discussed the advantages of enhancing the current centralized referral system into a truly universal system using the FCM referral process, form, and outcome tracking mechanisms together with other common referral entry points in the schools, hospitals, social service agencies—even online self-referral. This would assure that there is "no wrong door" for home visitation referrals.

Capacity for System Integration. The Elgin community is home to a vibrant, comprehensive, proactive Early Childhood System (ECS). Effective early childhood systems are marked by the obvious presence, easy access to, and community awareness of four major categories of services: 1) Early Learning –both at home and in the community; 2) Family Support—for the developing parenting role and for economic self sufficiency; 3) Health (including mental health) and Nutrition; and 4) Early identification, early intervention, and services for special needs children. The Elgin ECS is well-developed in these four service categories and is designed to be culturally and linguistically competent, family-centered, strengths-based, individualized, and coordinated across the four categories. The Elgin ECS frequently collects data, plans improvements, and evaluates outcomes. The Elgin ECS infrastructure has four key, interlocking components: The All Our Kids Birth-to-Five Network (AOK Network), the Perinatal Committee, the Breastfeeding Coalition, and the Home Visitation Collaborative.

The members of Elgin's ECS are actively engaged in the county-wide AOK Network, which began in 2000. AOK exists to enhance county-wide ECS strengths, assess unmet needs, and develop assets to meet those needs through collaboration and coordination. Development of cultural competence among AOK partner agencies and their workforce is a key driver of

[11] Community Crisis Center participated in one of four "Developing A System of Care to Address Family Violence During or Around the Time of Pregnancy" grants awarded nation-wide by the federal Maternal and Child Health Bureau.

[12] The University of Illinois at Chicago Division of Specialized Care for Children, which operates Illinois' program for Children with Special Health Care Needs under Title V.

community engagement and effectiveness. Not only is culture respected by assuring linguistic competence and staff reflective of the community we serve, attention and training about the culture of poverty has also been an AOK focus. Outreach to minority community members is strategic and ongoing. Elgin AOK partners include many programs of the U-46 Elgin School District, the multiple U-46 parent/community Advisory groups, the City of Elgin, the Elgin United way, the Gail Borden Library, the Hispanic and African American Coalitions and groups, two community health centers, private sector health providers, the Elgin WIC and Family Case Management programs, child care centers, a domestic violence agency, home visiting and early childhood center-based programs, substance abuse, mental health, dental health, and early intervention providers, the faith community, and many more.

Macon County

Needs. Macon County was identified as a potential target area in the original MIECHVP Needs Assessment. It is a largely agricultural community, centered on the City of Decatur. The county's population was estimated to be about 108,000 in 2009, with nearly 8,300 children under six years of age. More than seven percent of families live on incomes that fall below the federal poverty standard and nearly ten percent of households are headed by a single parent. African-Americans comprise about 15 percent of the county's population. Slightly more than 1,400 births occurred to Macon County residents in 2008; nearly two-thirds (62%) of them were financed by the Medicaid program; more than half (53%) were born to single women and five percent were born to mothers under 17 years of age. The estimated rate of maltreatment of children under five years of age was 26.7 per 1,000 children in 2008.

Decatur, Macon County's seat of government, is primarily a manufacturing community with a large contingent of service-oriented businesses. It has at times been dubbed the "Soy Bean Capital of the World" and "Supermarket to the World" due to its major employers, Tate and Lyle (formerly Staley, Inc.) and Archer Daniels Midland, two major players in the global agri-business market. Other large employers in Macon County include Caterpillar, Inc, Pittsburgh Plate Glass, Ameren (a utilities company), and the school districts servicing each community. Additionally several hospitals and their satellites comprise the second largest employers in Macon County. Presently, Decatur suffers from a high unemployment rate with many families having to access services for the first time. According to the Bureau of Labor Statistics, the unemployment rate for Decatur for the month of February 2011 was 11.2 percent -- well above the state rate of 8.9 percent for the same period. This is down, however, from a high of 14.6 percent in February of 2010.

Resources. Macon County, known for its response in times of crisis and its caring attitude for those in need, is located in the center of Illinois in the heart of the agricultural community. Agencies within Decatur and throughout the larger community work collaboratively to address the social, emotional, and educational needs of its citizens. The Macon County area is a diverse community as the multi-national businesses attract families from throughout the world in their work places. Because others know Macon County for its generosity, it often serves as a welcoming environment to those new to the United States and to extended family members.

Macon County agencies, school districts, and community businesses have a long demonstrated history of collaboration to enhance the quality of life for residents of Macon County. This organized collaboration approach can be traced back to the 1980's at which time the county established a consortium of agencies, schools, and businesses that continues to function to share ideas and information. This consortium works collaboratively on several county wide grants and initiatives. The county has an active Local Interagency Council addressing Early Childhood challenges, especially for the developmentally delayed. The county responded to various initiatives from the State of Illinois by establishing Child and Family Connection #18, the All Our Kids Early Childhood Network, and the Early Childhood Education Consortium. Early childhood agencies have been serving the community for many years: Head Start for over 45 years; Baby Teaching Activities for Learning and Knowledge (Baby TALK), which originated in Decatur, for over 25 years; the Decatur Public Schools 0 to 3 and 3 to 5 year olds programming for over 20 years; Macon Resources for over 20 years. In addition, Macon County Health Department's birth-to-5 prevention programs have been in place for over 20 years.

These long standing collaborations, as demonstrated by Human Service Agencies Consortium, Local Interagency Council, EDCO, Obesity Coalition, Asthma Coalition, Autism Support Group, Homeless Council, Breastfeeding Task Force and Early Childhood Consortium exemplify the community's efforts to work collaborative for the better health and education of families in our community.

The breadth of this collaboration is illustrated by the involvement of the judiciary. The Macon County State's Attorney has developed a mental health court, a drug court and a teen peer court. The teen peer court is one of only a handful operating in the United States. It applies the principles of balanced and restorative justice to build a sense of community for defendants. Additionally, a Child Advocacy Center has been created to reduce trauma for children who are victims of violence. The Illinois Department of Corrections' Women's Division Center in Decatur has implemented infant-parent programming to support inmates with young children.

The availability of medical services is a community strength. Macon County is ranked 6th in the Illinois County Health Ranking in the area of clinical care services. Macon County has the Community Health Improvement Center, a Federally Qualified Health Center, to serve low income adults and children. The Macon County Health Department houses a dental clinic for low income children and emergency services for adults. There are two state-of-the-art hospitals within the county. Women are provided opportunities for prenatal care at two separate locations.

It can be said that Decatur, as the hub of Macon County, serves as a central location to a wide range of programming, with entities collaborating on diverse activities for families of young children. This collaborative foundation places Macon County in the position for responsive expansion upon receipt of this grant. We have information from Needs Assessment I on the risk factors.

Existing home visiting services. There are six home visiting programs in Macon County. This includes two Parents as Teachers programs supported by ISBE; one Healthy Families Illinois program supported by IDHS; an Early Head Start program and two programs that use the Baby TALK model. The Parents as Teachers programs serve a combined total of 355 families, the

Healthy Families Illinois program is serving 68 families and the Early Head Start program is serving 22 families. Two Parents as Teachers programs have closed since March 2010; 80 families lost services as a result.

Existing mechanisms for screening, identification and referral. Currently each home visiting program has an individualized screening tool. There are several key elements included in the screening process for all home visiting agencies. These include a family risk analysis, health history, developmental screening, and personal interview. Families and children are identified in several ways including:

- Advertisement through local media
- Area screening days at schools, libraries, and daycares
- Births at county hospitals and regional high risk birth centers
- DCFS and related child welfare agencies
- Flyers distributed in at-risk neighborhoods
- Medical card recipients notification to health department
- Middle school and high school counselors and school nurse referrals
- Physicians
- Pregnancy Centers
- Prenatal Clinic – Health Department
- Pre-school screening parent questionnaires
- School registration forms
- WIC
- Word of mouth

Although several locations and methods are utilized to promote programming and identify potential clients, once identified, there is a range of referral processes. Commonalities exist in the priority identifiers, parent interviews, and informal observation. If the informal observation with the child indicates immediate follow-up, this is addressed. The home visiting programs do not currently utilize a central intake and referral process, however they do meet monthly to ensure there is no duplication in services.

Referral Resources. Women are currently screened for perinatal depression by several community agencies. The Mental Health Board has partially addressed this increasing need by placing counselors from Heritage Behavioral Health Center, in the FQHC and the Macon County Health Department, as well as its own facilities. The New Life Pregnancy Center and private mental health counselors also provide counseling services. Agencies such as Safe from the Start, Webster Cantrell Hall, St. Mary's Mental Health and Illinois Mentors provide group sessions and workshops for families. However, more services are needed. Mental Health service for families continues to be a need in the Macon County area.

Substance Abuse treatment providers include Heritage Behavioral Center and St. Mary's Hospital. Support for families such as parent education, referrals and screening dealing with these issues comes from Baby TALK, Health Department, CHIC, Parents and Teachers Programs and Early Head Start. These services are currently being prescribed through the

Mental Health and Substance Abuse Court utilizing Dove/ Heritage family services centers assisting parents and providing healthy environments for children.

Domestic Violence is initially addressed by a protective residential program for mothers and their children by Dove and followed with additional counseling support through Dove family sessions, Growing Strong Sexual Assault Center and Safe from the Start. Dove and Growing Strong provide a 24 hour crisis hotline.

Agencies such as Soyland Access to Independent Living (SAIL) , Starting Point at the Macon County Health Department, Prairieland Service Coordination, Step Forward and Macon Resources, Inc. provide case management, training sessions and transitional support for developmentally delayed parents. Life skill training and teen parenting classes are also provided through local high school special education departments, health department, Office of Rehabilitation.

Coordination of homeless services is provided by the Homeless Council. Day Services, temporary housing, and long term housing are provided by the Decatur Housing Authority, Homeward Bound, Grace House, Salvation Army, Virtue House, Men's Shelter, Oasis, God's Shelter of Love, and Heritage Behavioral Health. Good Samaritan Inn provides free lunches seven days a week. The Decatur Park District provides breakfast and lunch to children throughout the summer.

Multicultural services are provided by home visiting programs and the local school districts including bilingual home visitors and bilingual classrooms. Baby TALK, in conjunction with Richland Community College, provides a Family Literacy English as a Second Language program for adults. Decatur Public Schools, Johns Hill Magnet School, provides bilingual classrooms and family support for multicultural families. The local hospitals and health department utilize the state bilingual help line.

Existing 0-3 services. Child and Family Connections provide early intervention services to children from zero to three. The Macon County Health Department offers several 0-3 services such as: WIC, Family Case Management, and Immunizations. CHIC offers well-child visits and immunizations both onsite and at the Health Department. Pershing Early Learning Center provides nursing services to children zero to five and family fun activities to develop core readiness skills, and playgroups. Baby TALK provides newborn visits at the local hospitals, socialization activities such as: Lapsits, Kindermusic, Come Sign with Me, Family Literacy, Teen Parent Alternative Education, Early Head Start Center Based, and STEPS. New Life Pregnancy Center offers family activities and parent education workshops. Communitywide organizations such as: Rock Springs, the Greater County YMCA, Decatur Parks and Recreation Department, and community libraries offer socialization and early learning activities. There are 62 licensed home daycare providers and 32 childcare facilities within Macon County.

Plan for coordination: In order to continue to support three separate models of home visiting while consolidating and managing a collaborative consortium, the providers will join into an association to monitor and maintain a formal process of referrals. Each entity will continue to identify and screen families and assign as appropriate to their programming. Families who do

not qualify for the organization administering the screening will be brought to the consortium for review. These families will be referred then to another member of the consortium or to one of the area family resources liaisons for additional follow-up. The area liaisons will then further assess and determine referrals to the most appropriate agency or organization. Initially, the Consortium will meet on a weekly basis so as to make decisions in a timely manner and to avoid allowing any child to drop through the cracks.

Capacity for Integration. Integrating these home visiting services into an early childhood system has been a task which the Decatur Area Education Coalition (EDCO) is prepared to undertake with its partnering Macon County agencies, community businesses, and school districts. EDCO has formed 3 teams each with an academic and age range focus.

Team 1 focuses its efforts on readiness for Kindergarten. For the last four years, team members have worked collaboratively to assess more than 900 4-year-old children in county day care centers, preschools and private home centers to provide the community with data on the readiness of its children for kindergarten.

Team 1 now has 2 sub-teams: one directly focused on daycares, private home care and services available for families with prenatal through 3 year old children; the second working with daycares, preschools, private home care to prepare children ages 3-5 for kindergarten. The two committees have generated community awareness campaigns and initiatives which have encouraged families in the community to expand their knowledge of readiness for school and to encourage early educational opportunities which benefit families who are most at risk of academic failure in our community.

The prenatal through age 3 sub-team is organizing a central referral process which will enable the neediest families in the community to access services in a seamless manner and keep families engaged with these supports until the children enter school or the family has met its goals. Through monthly meetings, EDCO Team 1 is able to explore research and its impact on working with small children, share specific information about how to access community services and analyze data which is showing the impact of the team's initiatives in the community. What is specifically unique about Team 1 and each team of the Education Coalition is the extent to which community business partners, social service agencies, schools and parents have banned together to make a large impact in their community. With the success of Team 1 efforts with Kindergarten screening in the community and improved readiness in the county, EDCO is positioned to shepherd home visiting expansion in the county.

Section 2: State Home Visiting Program Goals and Objectives

The goals and objectives for Illinois' Strong Foundations Partnership reflect four essential elements of our strategy: 1) operating home visiting programs with fidelity to their models; 2) developing strong referral networks for home visiting program participants in order to achieve the national benchmarks; 3) testing a universal screening and coordinated intake system; and 4) strengthening the early childhood service delivery system.

The goals and objectives are as follows:

The statewide system of evidence-based and innovative approaches to home visiting and the state and local infrastructure necessary to support effective service delivery will be enhanced.

1.1 Implement or expand evidence-based and innovative home visiting models and test service delivery enhancements in selected target communities.

1.2 A system to screen all pregnant women and families with newborns and link them to a full array of perinatal and early childhood services will be developed and tested in at least one target area.

1.3 The agencies and individuals in the target area who serve families with young children are organized into an effective and efficient service delivery system.

1.4 The state agencies that belong to the Strong Foundations Partnership will develop and maintain the staff capacity, information technology and partnerships required to support the operation of high-quality, effective home visiting programs.

Home visiting programs operate with fidelity to national models

2.1 Program staff meets the national model's education, experience and professional licensure requirements, reflects the cultural and linguistic diversity of the community they serve and demonstrates cultural competence.

2.2 Program staff completes the training required for their role in the project.

2.3 Program staff regularly receives reflective supervision

2.4 The home visiting program's caseload remains within 75% of capacity.

2.5 The home visiting program provides (75% of the expected number of complete visits for 75% of participating families).

2.6 The home visiting program collects information about its operation and uses that information to improve performance.

Home visiting programs are embedded in the overall system of services for families with young children.

3.1a Local home visiting programs will execute Memoranda of Understanding or other formal agreements with preventive, primary and health care, mental health, substance abuse, domestic violence, developmental disability, homeless, and Limited English Proficiency service providers in the community, as well as regional perinatal care services and Early Intervention access points.

3.1b Local home visiting programs will execute Memoranda of Understanding or other formal agreements with other social service providers in the community.

Home visiting programs improve the lives of participating families in the areas described by the national benchmarks

4.1a. Home visiting programs improve the health of women by helping them gain health insurance coverage, by linking them to preconceptional, prenatal and primary care services, through screening for perinatal mood disorders, substance abuse, developmental delay and other conditions, and by linking women to community services to address these conditions. (This is the portion of Benchmark 1 that applies to women of child-bearing age.)

4.1b. Home visiting programs improve the health of children through the promotion of breastfeeding, by helping them gain health insurance coverage and by linking them to preventive and primary care services. (This is the portion of Benchmark 1 that applies to children.)

4.2 The rate of childhood injury, abuse and neglect among participating families will decrease over time. (This is part of Benchmark 2.)

4.3a Parents in participating families will improve their knowledge of child development, improve their parenting skills and avoid the use of harsh discipline in order to promote their children's cognitive, emotional and social development. (This is part of Benchmark 2.)

4.3b. Children in participating families will meet developmental milestones for cognitive, language, motor, social and emotional development; children who exhibit developmental delays will be linked to Early Intervention services. (This is part of Benchmark 3.)

4.4 Participating families will be screened for the presence of intimate partner violence; affected partners are referred for services and develop a safety plan. (This is Benchmark 4.)

4.5 Participating families will increase their educational attainment, employment and household income and obtain health insurance coverage. (This is Benchmark 5.)

4.6a Participating families affected by any of Illinois' six high risk conditions[13] are identified and linked to additional assessment and treatment services. (This is part of Benchmark 6.)

4.6b Participating families are screened or assessed for their need of additional health or social services and are linked to available service providers. (This is part of Benchmark 6.)

[13] Maternal perinatal mood disorders, substance abuse, intimate partner violence, parental developmental delay, homelessness and limited English proficiency.

Home Visiting is Part of a Comprehensive System. Home visiting programs play a critical role in the development of a comprehensive, high-quality early childhood system. Home visitors provide support and bring knowledge of child development and community services to families who may be isolated by service barriers (e.g., transportation or language) or who may be affected by circumstances that interfere with the development of a healthy bond with their young children (e.g., a perinatal mood disorder). Providing services in the home setting provides a more complete understanding of the family's needs and circumstances. Home is the child's natural and most comfortable environment. Illinois' goals and objectives were developed to illustrate the role of home visiting programs in a comprehensive system.

In addition to the implementation of home visiting programs at the community level, the Executive Committee will continue its efforts to develop the state and local infrastructure required to support the effective operation of home visiting programs. One of the system enhancements will be the development and testing of a universal screening and coordinated intake system in at least one of the MIECHVP target areas. In general, this component will be modeled after the system developed and used by the New Jersey Department of Children and Families and Prevent Child Abuse New Jersey as a part of their Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment grant. Additional information on this component is provided in Section 3.

The Executive Committee will draw on many years of experience gained through the development and implementation of the All Our Kids (AOK) Early Childhood Networks to strengthen the early childhood service delivery system in the MIECHVP target areas. This component is described in Section 3. Further, the Early Learning Council has a cross-committee, cross-system work group focused on community level collaboration and systems building, the Community Systems Development Workgroup. This work group provided technical assistance to the semi-finalist communities for MIECHVP and will continue to provide technical assistance to the Target Areas. The staffing, information technology and partnerships that will be required at the state level are described in Sections 4 and 6. The Executive Committee is seeking to develop an integrated approach to supporting home visiting from the state level. This includes training of home visitors, monitoring local program operations and continuously improving their quality through the analysis of program data and the provision of additional technical assistance and training. This integrated approach is intended to support home visiting programs of all types, whether they are established, evidence-based models or innovative, promising approaches. In support of this effort, the Executive Committee plans and executes the activities of the EBHV and MIECHVP grants synergisticly. Goal 1 and objectives 1.1 through 1.4 have been developed for this aspect of the project.

To be effective, home visiting programs must operate with fidelity to the guidelines established by its model developer and use management information to continuously improve the quality of service delivery. Goal 2 and objectives 2.1 through 2.6 have been proposed to address this aspect of the initiative.

Home visitors bring information and help new parents promote their children's development reduce their risk of injury or maltreatment. They also link families to other community services, such as preventive and primary health care, mental health and substance abuse treatment

services, domestic violence shelters and services, child care, transportation, education, employment, food, shelter, income assistance, and many others. Goal 3 and objectives 3.1a and 3.1b and Goal 4 and objectives 4.1 through 4.6 have been proposed to address the improvement of parents' knowledge of child development and to address the importance of linkages to community services in order to improve the health of participating families and achieve the national benchmarks for the MIECHVP.

A logic model for Illinois' Maternal, Infant and Early Childhood Home Visiting Program is presented in Appendix 5. The model summarizes the four basic components of Illinois' strategy: universal screening and coordinated intake; operating home visiting programs with fidelity to national models; connecting home visiting programs to the providers of services required by Illinois' high-risk target populations; and organizing all early childhood service providers into a coherent and effective service delivery system.

Section 3: Selection of Proposed Home Visiting Models and Explanation of How the Models Meet the Needs of the Targeted Communities.

Selected Models and Adaptations

The Illinois Home Visiting Task Force has endorsed the following evidence-based models for implementation through the MIECHVP:

Early Head Start
Healthy Families America
Healthy Steps for Young Children
Nurse-Family Partnership
Parents as Teachers

These home visiting models are already in widespread use in Illinois. The Strong Foundations Partnership has experience with Healthy Families America and Parents as Teachers. One of the Partners, the Ounce of Prevention Fund, has experience with the implementation and support of Early Head Start and Nurse Family Partnership. Healthy Steps for Children has been implemented through the efforts of program staff at Advocate Health Care, a multi-hospital health system based in Chicago. The Executive Committee and the Home Visiting Task Force may reconsider the list of approved models over the course of the initiative.

Years of experience with home visiting programs in Illinois and the needs assessment for the MIEC Home Visiting Program identified six high-risk groups of participants: families affected by mental illness (primarily perinatal mood disorders); alcohol or substance abuse; domestic violence; parental developmental delay; homelessness and limited English proficiency. The Home Visiting Task Force is strongly committed to implementing adaptations that will address the needs of these target populations over the course of MIECHVP funding. However, no "promising approaches" will be implemented during the first year. The Executive Committee believes that it is important to gain more experience in working with the federal partners on MIECHVP before proposing the implementation of adapted models.

Experience with the Selected Models

Early Head Start

There are 30 Early Head Start grantees in Illinois. These grantees serve 61 of Illinois' 102 counties and 42 of Chicago's 77 community areas. Altogether, the program can support 4,735 children. Through the allocation of American Recovery and Reinvestment Act (ARRA) funds, the program recently expanded by more than 2,000 children and five new grantees to serve eight more Community Areas in the city of Chicago, 44 more communities in suburban Cook County and 27 more counties downstate. The total federal investment in Early Head Start is $50.5 million in Illinois; the new ARRA funds more than doubled the federal government's investment. Of the 30 Early Head Start programs in Illinois, 28 programs currently operate home visitation services as one of their program service delivery options; 43 percent of the children in Early Head Start in Illinois are served through programs that offer the home-baed option. . One member of the Partnership, the Ounce of Prevention Fund, is an Early Head Start grantee, supporting 289 slots using the home visiting and center-based program options, as well as with services to pregnant women. Early Head Start home visiting programs utilize a variety of curricula including the Parents as Teachers' "Born To Learn" curriculum and can obtain training in its use through the Illinois Birth To Three Institute.

Early Head Start programs obtain training through the Early Head Start National Resource Center, the 20 national Centers of Excellence, the Region V Training and Technical Assistance System and from various local resources. The Region V Training and Technical Assistance system includes intensive on-site management systems consultation for new programs as well as programs that are having difficulty meeting the national performance standards. In addition, the Region V Training and Technical Assistance system provides ongoing technical assistance to Head Start and Early Head Start grantees in the area of early childhood development through state-based teams of Early Childhood Education Specialists. Each state team includes an Infant Toddler Specialist with expertise and training specifically in working with the birth to three population.

The federal Region V Office of Head Start is responsible for program monitoring and quality assurance. Head Start programs submit monthly enrollment reports, annual program performance and demographic data reports, semiannual progress reports, and annual continuation application and an annual self-study. In addition, based on the information gathered from various data sources, the Regional Office of Head Start conducts annual Risk Management meetings with each Head Start grantee to identify potential areas of programmatic and fiscal risk and determined action steps to mitigate these risk factors. Nationally, the Office of Head Start conducts a comprehensive, on-site, program and fiscal compliance reviews of each grantee, every three years. Based on the results of these reviews, Head Start programs may receive one or more additional follow-up on-site monitoring reviews to ensure that corrective actions have been fully implemented. For those communities implementing Early Head Start as a program model for the Strong Foundations Partnership, the Executive Committee will work with the Office of Head Start to develop a memorandum of understanding to share monitoring information and coordinate monitoring activities. [

A regional staff member from the Office of Head Start and the State Head Start Collaboration Office have been active participants in the Home Visiting Task Force. The Illinois Head Start Association is an important source of training, technical assistance and advocacy at the state level.

Healthy Families America

Illinois currently supports 47 Healthy Families America (known as Healthy Families Illinois) programs across the state. The Illinois Department of Human Services funds 37 of these programs directly and nine programs indirectly through the Ounce of Prevention Fund as a part of the Parents Too Soon program. The Illinois State Board of Education funds one Healthy Families Illinois program. The first Healthy Families Illinois programs were funded by IDHS in 1997. This was followed two separate program expansions in subsequent years. The currently active programs have received funding for at least ten years. The Parents Too Soon programs, which date back to the early 1980's, began conversion to evidence-based models beginning in 1997. About half of them chose HFI and one chose NFP. (The remaining sites converted to PAT in 2008.) The ISBE began funding its HFI program in SFY'06.

The Illinois Department of Human Services has provided funding since 1997 to train Healthy Families Illinois program staff through the Ounce of Prevention Fund's Illinois Birth To Three Institute. Core, advanced, periodic and special topic training programs are provided for Family Assessment Workers, Family Support Workers, program supervisors and program managers.

IDHS Division of Community Health and Prevention staff are responsible for program monitoring and quality assurance. Programs are reviewed through regular site visits using a protocol developed from Healthy Families America standards; the current version is based on the "Healthy Families America Self-Assessment Tool 2008-2010". (This review does not replace of the formal peer review accreditation process. However, IDHS does provide supplemental funds to offset the cost of accreditation when sites are ready to undertake the process. Thirty-three Healthy Families Illinois programs are currently accredited by Healthy Families America.)

The IDHS also supports local Healthy Families Illinois programs through the use of the Cornerstone management information system. This system collects data on participant characteristics and program activities (e.g., number and frequency of home visits), referrals for services and, through linking with existing data systems, data on health service utilization and maternal and infant health outcomes. The Ounce of Prevention Fund provides "OunceNet" software for use by all of its Parents Too Soon programs, regardless of home visiting model.

Healthy Families Illinois is supported by a healthy and effective state-level collaboration, the Healthy Families Working Group. The Working Group is co-chaired by the Vice President of Voices for Illinois Children and by IDHS' Bureau Chief for Child and Adolescent Health. The Working Group includes members from child advocacy organizations, parents, academics, the Birth To Three Training Institute[14] and local Healthy Families Illinois program administrators. The group formed in December 1994 to formulate a plan for implementation of the Healthy

[14] Currently operated by The Ounce of Prevention Fund. The contract is periodically rebid.

Families America model in Illinois. The group has remained active for the last 17 years and continues to meet regularly.

Healthy Steps for Young Children

Illinois has five Healthy Steps for Young Children program sites, all of which are located in the Chicago area. Two of them are based in pediatric residency programs in children's hospitals, one is based in a family practice residency program, one is based in the department of pediatrics at a university children's hospital and one is based in a Community Health Center. The staffs of these organizations have completed Healthy Steps training and have employed Healthy Steps Specialists who provide home visits. Two of the sites are part of the original national demonstration project from 1997 and the others were added in 2001. Seven Community Health Centers or Federally-Qualified Health Centers have completed training but have not hired Healthy Steps Specialists. In addition, the IDHS' Maternal and Child Health Nursing Consultants have completed full Healthy Steps training and the Child Care Nurse Consultants who are part of Illinois' Healthy Child Care America initiative have completed partial Healthy Steps training.

Advocate Healthcare's Healthy Steps program also works closely with the Illinois Chapter of the American Academy of Pediatrics and the Illinois Department of Healthcare and Family Services to implement the Enhancing Developmentally-Oriented Primary Care (EDOPC). Also based on Bright Futures, the EDOPC project provides training for Federally-Qualified Health Centers and Community Health Centers to support child development. The EDOPC project does not include the full array of topic required for recognition as a Healthy Steps program and does not include home visiting. However, clinics that have completed EDOPC training could easily become Healthy Steps projects with additional training and staff.

Training and technical assistance are available from Advocate Health Care's Healthy Steps Program. The basic, four-day Healthy Steps training is conducted annually and technical assistance is provided upon request by program staff. Continuing education is provided through on-site training, teleconferences, the EDOPC project's web site (www.EDOPC.net now has five topics available), and the Healthy Steps multi-media training kit. The EDOPC project provides monthly technical assistance calls in which Healthy Steps sites participate. Healthy Steps program staff also assist local sites in recruiting Healthy Steps Specialists and in linking participating clinics to local community resources.

As part of Healthy Steps' Quality Assurance program, the Director of Healthy Steps at Advocate Health Care observes Healthy Steps interventions on site and meets monthly with each of the Healthy Steps Specialists for two hours to review cases, introduce current literature on relevant topics, and offer assistance with problems encountered at sites. The Director and Healthy Steps training and consultation staff, of whom there are four, also meets with the entire Healthy Steps team monthly at their site during the first year, reviews clinical concerns, provides ongoing training and technical assistance, collects data compiled by sites monthly, and maintains records of implementation. Sites have the opportunity to receive all of the original Healthy Steps training (three days) and the additional EDOPC training (one day). Full training is four days.

Healthy Steps sites maintain a data base of what they do, the number of patients they see, the number and types of screenings completed, the number of home visits completed, the number of referrals to community resources and other home visiting programs. As part of Healthy Steps and EDOPC training, participants complete pre- and post-testing and training evaluations. Sites are given sample protocols to follow and schedules of interventions such as screening according to American Academy of Pediatrics policy recommendations and the Bright Futures periodicity schedule. Sites are also given templates to conduct chart reviews quarterly.

The Strong Foundations Partnership is implementing Healthy Steps as a secondary model of home visiting. Communities that are interested in using this approach must also implement one of the other home visiting models and coordinate the activities and services of both programs. Healthy Steps was designated as a secondary strategy because of the limited number of home visits required during the first three years of life.

Nurse-Family Partnership

Illinois has three Nurse Family Partnership programs. One is located in Kane County, west of Chicago; one is located in Mount Vernon, Illinois (in the southern part of the state) Illinois and the newest program, which is beginning operations as this plan is prepared, is located on the south side of the city of Chicago. These programs have diverse funding sources. Two are supported by IDHS funds through the Ounce of Prevention Fund as a part of the Parents Too Soon program. The Kane County program is supported by funds from ISBE and local resources. Two more programs, one in Lake County (north of Chicago) and one in DuPage County (west of Chicago) are being launched by local health departments with county funds.

The Nurse Family Partnership programs obtain training from, and as prescribed by, the Nurse Family Partnership National Service Office (NSO) in Denver, Colorado. Programs receive monthly telephone follow- up (for clinical nursing support, ongoing education for supervisor and staff, the use of ETO data to inform and strengthen the services) and an annual site visit by a nurse consultant from the NSO. Program data, collected through the NSO's Efforts to Outcomes™ information system, are used to continuously improve the quality of program operations. A full quality assurance review is conducted on-site every three years by the National Service Office as a part of renewing the site's contract with the NSO. The Nurse Family Partnership Program Developer for the Midwest Region has been an active participant in the Home Visiting Task Force since its inception.

Parents as Teachers

The rapid expansion of Parents as Teachers (PAT) in Illinois began in 2006 when the ISBE redirected funds for the "zero to three set-aside" within the state-funded Early Childhood Block Grant. Recipients of these funds were required to support evidence-based models. HFA, NFP and PAT were among the approved models. The ISBE currently funds 104 Parents as Teachers programs. Nine more Parents as Teachers programs are funded by IDHS and operate through the Ounce of Prevention Fund as a part of the Parents Too Soon program. To the best of our knowledge, all 113 of Illinois' Parents as Teachers programs are currently affiliated with the Parents as Teachers national office. None of them has yet achieved Commendation.

Illinois has a well established state infrastructure for the support of Parents as Teachers. This includes the Illinois Birth to Three Institute, which is responsible for training all staff of Parents as Teachers programs. The Institute conducts basic and continuing training for parent educators, program supervisors and program managers and provides technical assistance to assure quality statewide. The Institute only uses trainers who have been certified by the Parents as Teachers National Office to conduct this training and uses curricula that have been approved by PAT. The ISBE selected the Ounce of Prevention Fund to perform the functions of the PAT State Office beginning January 1, 2008.

The State Office provides technical assistance to PAT programs. This begins with the review of the program plan submitted by each site. Once a site's program plan has been approved and site personnel have completed Foundational and Model Implementation training, technical assistance staff from the State Office schedule a site visit to occur between three and six months after the completion of training. Staff complete a program survey during this site visit; this information is used to formulate a technical assistance plan for the site. Additional assistance is provided by telephone and electronic mail. The State Office also performs an annual program review which is focused on fidelity to PAT's Essential Requirements. After three years of operation, PAT programs are eligible to apply for Commendation, the formal recognition of a site's conformity with the Essential Requirements. Achieving Commendation requires the completion of a self-study, video recording of home visits and parent groups and a site visit by a review team. PAT programs supported by MIECHVP funds will be expected to apply for commendation. The State Office will assist sites in preparing for Commendation.

Of the 104 ISBE-funded PAT programs, 53 use the national Visit Tracker© software developed by DataKeeper Technologies.

While there is no state-level collaborative body for PAT that is comparable to the Healthy Families Working Group, state leaders from ISBE have been active members of the Strong Foundations Partnership. Staff from many local PAT programs serve on Home Visiting Task Force committees.

Ensuring Implementation with Fidelity

Each of the models selected for replication in Illinois is based on a set of criteria articulated by the model developer. For Early Head Start, they are contained in federal program requirements. For Healthy Families America, they are contained in that organization's "Critical Elements for Successful Programs." For Healthy Steps, the minimum requirements are presented in the "Healthy Steps for Young Children Policy on the Use of the Healthy Steps Name and Logo." For Nurse Family Partnership, they are contained in the "Model Elements." For Parents as Teachers, program criteria are found in the "Essential Requirements." Illinois' approach to quality assurance is to ensure that local program operations conform to these standards. This assurance is obtained through the collection and analysis of both quantitative and qualitative information about program performance.

The first step in the process is to examine a candidate provider's plan for implementing the model. For example, prior Requests for Proposals (RFP) issued by IDHS for Healthy Families Illinois have asked respondents to describe how each of the Critical Elements for Successful Programs will be implemented in the program they are proposing. Proposal reviewers received training on the Critical Elements; in order to receive consideration for funding, applicants were required to demonstrate to reviewers that they understood the model's standards and to present a feasible plan for implementing them. The same approach will be used in reviewing the program plans that will be submitted by providers in the Target Areas. (More information on the local program plan is provided in Section 4.)

The second step in quality assurance is training. New staff in HFI or PAT programs receive training through the Illinois Birth To Three Institute. New staff in an NFP program receive initial training, as well as ongoing education and clinical support, through NFP's National Service Office. [Early Head Start] Staff in Healthy Steps programs may receive training from the Advocate Health Care in Chicago.

The third step is implementation support. This work begins through the establishment of a working relationship between the community provider and one of the Division's Community Support Services Consultants. The consultant will orient the provider's staff to the Division, assist the agency in developing relationships with other organizations in the community and monitor the agency's progress in program implementation through regular contact.

The fourth step in quality assurance is the definition, collection, analysis and application of information on program operations. Each model's standards serve as the basis for identifying the data that are required to measure the extent to which a program has been implemented and operated with fidelity. Both quantitative and qualitative information are required to measure fidelity. The quantitative data has been operationally defined in the model-specific information systems developed to support these programs. (More information on the information systems that Illinois will use for continuous quality improvement may be found in Section 4.) These data will be summarized and used by local program staff, state program managers, Community Support Service Consultants, trainers and others to describe the current state of program operations and compare performance to each model's standards. The application of data to improve performance completes the process of continuous quality improvement and quality assurance. The information system that IDHS now uses to support Healthy Families Illinois programs, Cornerstone, produces management reports for Healthy Families Illinois that can be used routinely to monitor and improve program performance.

Qualitative data for quality assurance are collected through on-site examination of program records. These data are especially valuable in examining the delivery of the program's curriculum and other aspects of the content of the home visit itself. These data are also useful in examining the extent to which participating families' service needs have been addressed. For the Division of Community Health and Prevention, this process is referred to as Quality Review and Support. It is conducted less frequently (from annually to triennially), the results are reported to local agencies and division administration more formally (through a written report) and the report may require local agencies to change certain aspects of program operation (to conform with state or federal statute or regulation) or recommend that changes be made to improve

program performance. If changes are required in response to a program review, completion of the corrective action is also formally documented. These activities will be closely coordinated with the technical assistance and consultation provided by the PAT State Office and NFP's National Service Office.

The Illinois Department of Human Services and the Illinois State Board of Education encourage (but do not require) local Healthy Families Illinois and Parents as Teachers programs to formally affiliate with the national organizations that support these models and to complete the model developer's independent quality assurance process ("accreditation" for Healthy Families America and "commendation" for Parents as Teachers). IDHS provides financial support for a limited number of Healthy Families Illinois programs to complete the accreditation process each year. Currently, 33 Healthy Families Illinois programs are accredited by Healthy Families America. All 110 Parents as Teachers programs are affiliated with the Parents as Teachers national organization, but none of them has achieved commendation. NFP does not have an analogous process; the NFP's NSO executes a contract with each local agency that is implementing the model. An on-site quality assurance review is conducted triennially prior to contract renewal. The federal Office of Head Start requires monthly, semiannual and annual reports and an annual continuation application from local implementing agencies. Performance problems may be addressed during the preparation of the annual continuation application. The Office of Head Start also conducts an on-site program review every three years. Healthy Steps for Young Children has specified requirements for using the Healthy Steps name and logo; no formal periodic review of program operations is conducted by the model developer.

Four challenges to maintaining fidelity in the operation of home visiting programs can be anticipated. First, the availability and quality of program training must be maintained. Illinois will continue to allocate resources to training and ensure that training is regularly available and accessible to programs across the state. Trainers must also continue to meet national standards. Second, the state funding agencies (IDHS, ISBE and the Ounce of Prevention Fund) must increase their commitment to collecting, analyzing and applying program data for continuous quality improvement, quality assurance and outcome evaluation. This includes a sustained commitment to the information systems used for this purposes, as well as the staff required to analyze and interpret the data and assist local organizations in applying the information to improve program performance. Third, local home visiting programs must recruit and retain a qualified workforce, provide program staff with adequate training and supervision and ensure that their staff is not overburdened with excessive caseloads. Finally, state level leadership must maintain its commitment to operating local programs with fidelity to their national models. The state of Illinois has demonstrated its ability over the last 15 years to maintain the availability and quality of training, data collection and analysis and leadership. Therefore, most of these risks and challenges are minimal. However, the state's economic downturn has resulted in delayed payments to local service providers; this, in turn, has caused layoffs of qualified and experienced staff at the local level and the closure of HFI or PAT programs in some communities.

Matching Models to Community Needs

The process of engaging communities in matching models to their own needs began with the invitation to the semi-finalist communities described in Section 1. The invitation was issued in

mid-April (2011) and the presentations occurred in mid-May. The chair of the Early Learning Council's Systems Development Workgroup, a work group member with system development expertise, conducted a technical assistance webinar shortly after the invitation was issued. This chairperson also provided technical assistance to interested communities in early May. In addition to the community presentations, each team prepared a written description of community needs and resources and presented a justification for selecting one or more of the primary models.

Two "toolkits"[15] currently in use in Illinois were developed by the Community Systems Development Work Group with financial support from IDHS' Supporting Evidence-Based Home Visiting Programs to Prevent Child Maltreatment grant. The first toolkit, the *Community Systems Development Resource Toolkit: Supporting Local Communities in Collaboration and Partnership Building*, provides information on community systems in Illinois, along with a set of 'tools' (or strategies) for developing and sustaining local community collaborations. A companion toolkit, the *Resource Toolkit for Home Visiting Programs Serving Infants, Toddlers and Their Families: Implementing a Research-Based Model*[16], serves as a comprehensive resource guide for communities that are interested in developing or expanding evidence-based home visiting services. This toolkit was used by the technical assistance team to assist interested communities with the process of assembling a collaborative local planning team, assessing community needs and resources, identifying potential funding sources, developing a strategic plan, and selecting the home visiting model or combination of models that best meets the communities' needs.

The organizations that participated in the technical assistance provided to each community are listed in Table 3.

Chicago South Side. Expanded home visiting programs in Englewood, West Englewood and Greater Grand Crossing would meet a critical need for early intervention for the community's highest-risk families. The Planning Team has selected the Nurse Family Partnership program, Healthy Families Illinois, and Parents as Teachers based on the needs and strengths of the target communities. The selection of the Nurse Family Partnership program is based on the extremely poor maternal and child health outcomes in the community and the strong medical providers (ACCESS, Mercy Family Health Center, and the Chicago Department of Public Health's Englewood Clinic) which are community assets and have the relationships, infrastructure, and experienced required to implement NFP. The planning team selected HFI based on the very high rates of child abuse and neglect in the community and the fact that two members of the planning team, Family Focus Englewood and Henry Booth House, implement accredited HFI programs with a broad reach in the target communities. The selection of Parents as Teachers is based on our commitment to supporting parents in the community with limited resources and the need to ensure that children develop appropriately to succeed in school. Children's Home + Aid and Family Focus Englewood currently offer PAT in Englewood.

[15] Both toolkits were developed by the Early Learning Council's Systems Development Workgroup, under the leadership of the Executive Director of Positive Parenting DuPage.

[16] This toolkit was adapted from a similar document developed by the Infant Toddler Committee of the Early Learning Council for the Illinois State Board of Education for programs supported by the Early Childhood Block Grant.

Table 3
Participation in Technical Assistance (TA) for MIECHVP

Target Community	TA Requested	TA date	# Participants	Organizations represented
South Chicago Cluster	Yes	May 6th	18	Chicago Department of Public Health Children's Home & Aid La Rabida Children's Hospital Child & Family Connections 8 Easter Seals Family Focus Access Community Health Network COFI COFI/Power PAC Department of Child & Family Services
West Chicago Cluster	No		1	DHS Project Launch
Waukegan Twp	Yes	May 10th 10am	10	Lake County Health Department United Way of Lake County One Hope United Child & Family Connections School District, Special Education Dept A Safe Place Child Serv NICASA
Cicero Twp	Yes	May 5th 3 pm	9	Through a Child's Eyes The Children's Center Family Focus Nuestra Familias Cicero AOK Network Pillars Children's Mental Health Initiative
Thornton Twp	Yes	May 5th Noon	16	Thornton Township Dolton Peoples Action Center CrossRoads Coalition ECHO Family Enrichment Program Infant & Early Childhood Mental Health Consultant Easter Seals Metro Chicago Child & Family Connections 12 Sadie Waterford The Network Center
Elgin	Yes	May 3rd 1pm	10	VNA Fox Valley U46 School District Family Focus Kane County Health Department Greater Elgin Family Care Center
Rockford	Yes	May 10th 2pm	10	Easters Seals Winnebago County Health Department Crusader Health Collaboration Initiative City of Rockford City of Rockford Head Start La Voz Latina
Macon County	Yes	May 9th – AM	13	Decatur School District 61 Baby Talk Macon County Health Department Early Head Start/Baby Talk Education Coalition Macon Resources
Vermillion County	Yes	May 5th 9:30am call	12	Center for Children's Services Vermilion County Health Department Aunt Martha's Child and Family Connections 708 Mental Health Board Big Brothers Big Sisters Family Education Support Services New Directions Treatment Center Cross Point Human Services East Central Illinois Community Action Early Head Start

City of Elgin. The Elgin early childhood coalition recommends that existing Parents as Teachers, Early Head Start, and Nurse Family Partnership Home Visitation Programs be expanded and that the Healthy Family Illinois which currently serves Aurora in the southern part of the county be expanded to serve families in Elgin. The HVC has enjoyed a long and effective partnership in meeting the diverse needs of families because a variety of Home Visitation models were available in the community to match these needs. This "big tent" approach to evidence-based home visitation is highly visible in Illinois as a means of meeting the needs for home visitation among all the at-risk subpopulations.

Macon County. The various providers in the Macon County Consortium are committed to building a system of collaborative support, screening every family, identifying needs, and delivering appropriate services to at-risk children in Macon County. Macon County service providers currently offer three of the four primary models of home visitation:

- Early Head Start – Home Based;
- Healthy Families Illinois; and
- Parents As Teachers.

After careful consideration and courageous conversation, the collaborative decision emerged to continue to utilize all three models as part of this grant request. Each model in its present use meets a specific need in the community. The issue is not one of service but one of the coverage to capture as many children in need as possible.

The expansions can be summarized as follows:

Models to be Expanded in Illinois' MIECHVP Target Areas					
	Proposed Expansion				
Community	Early Head Start	Healthy Families Illinois	Nurse Family Partnership	Parents as Teachers	Target Population
Chicago South	Yes	Yes	Yes	Yes	Pregnant women, teen mothers, first-time mothers, children who screen at high risk of abuse or neglect.
Elgin	Yes	Yes	Yes	New program to begin operation in June 2011	High risk by poverty or by definition
Macon County	Yes	Yes	Yes	No	Pregnant women, teen mothers, rural families and children currently on waiting list

IDHS will request program plans and budgets for each of the models in each of the communities to ensure fidelity in program design. The requirements for the program plan is discussed more extensively in Section 4.

Innovations and Promising Approaches

No funding for innovative or promising approaches to home visiting is included at this time. Financial support of these approaches will be considered as additional federal funds become available.

Additional Components of Illinois' MIECHVP

Two additional components will be developed and implemented as a part of Illinois' MIECHVP. First, the Executive Committee will develop and test a system for universal screening and coordinated intake for all early childhood services. The purpose of such a system is to ensure that every family in a community who might benefit from the array of available services and supports has the opportunity to take advantage of them. The development and testing of this system will require some time. The system must include entry points for pregnant women and families with young children of all ages (rather than limiting the system to newborns). Some of these access points include medical homes for women and children designated by Illinois' All Kids program, the Part C Early Intervention system (which will also be receiving referrals from home visiting programs), Illinois' regionalized perinatal care system and others. On the other hand, several early childhood programs, such as the Part C Early Intervention and Child Care programs, have regional intake or information and referral coordination systems in operation. This new approach will have to successfully interface with these existing systems. The Task Force will begin work on the design of this component during the next year. The coordinated intake system developed by the New Jersey Department of Children and Families and Prevent Child Abuse New Jersey for that state's Supporting Evidence-Based Home Visiting Programs to Prevent Child Maltreatment grant provides a starting point for development. Representatives from the New Jersey program participated in a conference call with the full Home Visiting Task Force on March 18, 2011 to present the model they have developed. The essential components include:

- A strategy for prenatal and post-partum engagement of all families with newborns in the target area.

- A procedure for identifying the family's service needs and linking them to medical homes and other appropriate community providers.

- Capacity for developing collaborative relationships with agencies that are serving pregnant women or newborns on the one hand and providing home visiting and ancillary services on the other hand.

- Connection to the data system for continuous quality improvement and outcome evaluation;

- Connection to the broader early childhood service delivery system in the community.

The Kane County All Our Kids Early Childhood Network (described earlier) developed a similar system to coordinate intake among home visiting programs. Kane County has nine home

visiting programs and all four of Illinois' primary models (Early Head Start, Healthy Families America, Nurse-Family Partnership and Parents as Teachers) are represented. The local health department manages the AOK Network and distributes eligible families among home visiting programs based on geography, target population and eligibility criteria. A similar approach will be developed and tested during the initiative in an endeavor to screen all pregnant women and families with newborns and link them to home visiting and other early childhood services.

The second addition to Illinois' MIECHVP is the development of strong local collaborations among parents and early childhood service providers. The Community Systems Development Workgroup supports the Partnership in carrying forward the broader state goal for birth to five services of raising awareness about the importance of community collaborations as well as provide technical assistance to build strong local community partnerships in Illinois' communities. Through use of the existing capacity building structures in place and coordinated by the CSD WG, the Partnership will be able to maximize upon efforts toward collaboration and best meet the needs of local communities. One such model that serves as an example of such local work are the All Our Kids (AOK) Early Childhood Networks, a local system-building effort to provide a comprehensive and coordinated system of care for families with young children. Through the Networks, early childhood providers coordinate services, reduce duplication and fill gaps in services, and maximize resources. AOK works to make families more aware of available services and to facilitate their access to those services. The networks were developed to implement public health's ten essential services[17] with a focus on early childhood system development and bring parents and community health human service providers together to build a more effective system. Currently, AOK Networks are operating in 11 local counties/community areas geographically distributed throughout Illinois. Nine of the networks are funded by IDHS and two are funded by ISBE.

The creation or enhancement of an early childhood collaboration in each of the target communities is intended to ensure that each home visiting program is firmly embedded in the community's service delivery system. The early childhood collaboration will also strengthen the relationships among Title V and other agencies which serve families with young children.

Section 4: Implementation Plan for Proposed State Home Visitation Program

This Section presents Illinois' plan for implementing and monitoring the MIECHVP in Illinois. The implementation plan is divided into state-level and local-level activities. This section concludes with the plan for on-going monitoring of local projects.

Implementation Plan

State Level

Policy and Standards. The Home Visiting Task Force, a standing committee of Illinois' Early Learning Council, brings together state policy makers, advocates, families, academics and service providers to advance the development of home visiting in Illinois. The Home Visiting

[17] U.S. Centers for Disease Control and Prevention. National Public Health Performance Standards Program: ten essential public health services. www.cdc.gov/nphpsp/essentialServices.html.

Task Force also serves as the strategic decision making and interagency coordination body for both Strong Foundations (the Supporting Evidence-Based Home Visiting Programs for the Prevention of Child Maltreatment grant) and the Strong Foundations Partnership (the MIECHVP grant). The full Task Force meets three or four times a year.

The development of the MIECHVP proposal, needs assessment and implementation plan have been guided by the Task Force's Executive Committee. The Executive Committee and the full Task Force recommend policy to the Governor's Office of Early Childhood Development, the Illinois Department of Human Services and the Illinois State Board of Education regarding the development, support, expansion, monitoring and evaluation of home visiting in Illinois, including the services that will be supported through the MIECHVP grant.

The Project Director for both Strong Foundations and The Strong Foundations Partnership is employed by the Governor's Office of Early Childhood Development. This ensures that implementation of both projects has the highest level of support within the executive branch. This level of leadership and management responsibility sustains Illinois' "big tent" approach to supporting many evidence-based and promising approaches to home visiting and to coordinating policy development and program management across agencies.

The Illinois Department of Human Services serves as the lead agency for implementing the MIECHVP in Illinois. The Department's Division of Community Health and Prevention is also responsible for the Maternal and Child Health Services Block Grant, and the Title V Director serves as the primary liaison with the federal Maternal and Child Health Bureau and the Administration for Children and Families on implementation of MIECHVP.
The Illinois State Board of Education's Division of Early Childhood administers the state-funded Early Childhood Block Grant. Approximately fourteen percent of the funds appropriated for the block grant are "set aside" to serve children between birth and three years of age. It is from these funds that ISBE supports more than 100 Parents as Teachers programs across the state.

The Illinois Department of Human Services and the Illinois State Board of Education are committed to supporting the replication of home visiting programs with fidelity to the standards established by the model developers. As described elsewhere in this Implementation Plan, both agencies have incorporated these standards into requests for proposals, training programs for local program staff, monitoring procedures, data collection systems and program evaluations.

Partner Organizations. The following organizations are represented on the Home Visiting Task Force:

State and federal agencies

- Administration for Children and Families, Region V
- Governor's Office of Early Childhood Development
- Illinois Children's Mental Health Partnership
- Illinois Department of Children and Family Services
- Illinois Department of Healthcare and Family Services
- Illinois Department of Human Services
- Illinois State Board of Education

- University of Illinois at Chicago Division of Specialized Care for Children

Parents

- B. Cervantes, Parents as Teachers
- K. Magnuson, Parents as Teachers
- K. Gillihan, Healthy Families Illinois
- R. Schubert, Healthy Families Illinois

Advocacy organizations

- Fight Crime, Invest in Kids
- Illinois Action for Children
- The Kids Public Education and Policy Project
- Prevent Child Abuse Illinois
- Voices for Illinois Children

Academia

- Chapin Hall at the University of Chicago
- Erikson Institute
- Northern Illinois University
- University of Illinois at Chicago, Institute for Juvenile Research
- University of Illinois at Urbana-Champaign, Early Childhood and Parenting Collaborative

Private Funders

- The Ounce of Prevention Fund.
- The United Way of Metropolitan Chicago
- McCormick Foundation
- Irving Harris Foundation

Service Providers

- Adolescent Health Center, Healthy Families Shawnee Program
- Aunt Martha's Youth Service Center
- Baby TALK
- Carole Robertson Center for Learning
- Chicago Department of Family Support Services
- Chicago Public Schools
- Child Abuse Council, Quad Cities
- Children's Home and Aid
- Children's Home Association of Illinois, Good Beginnings
- Chinese American Service League
- Community Counseling Centers of Chicago
- CPS Community Partnership Program
- Dupage County Health Department
- Easter Seals Children's Development Center

- Easter Seals, Joliet Region
- El Valor
- Family Focus
- Family Focus Englewood
- Gads Hill Center
- Health Connect One
- Healthy Families (VNA of Fox Valley)
- Heartland Alliance
- HIPPY
- Infant Welfare Society of Evanston
- Kane County Health Department
- Lake County Health Department and Community Health Center
- LaVoz Latina
- Metropolitan Family Services
- New Moms, Inc.
- Parenthesis Parent - Child Center
- Positive Parenting DuPage
- Southern Region Early Childhood Programs, Carbondale
- Stephenson County Health Department
- Teen Parent Connection
- Teen Parent Program at Chicago Child Care Society
- Women's Treatment Center, Chicago

As a part of establishing policy for Illinois' MIECHVP, the Executive Committee assures the following:

Individualized Assessment and Service Plan. The Home Visiting Task Force, the Illinois Department of Human Services and the Illinois State Board of Education assure that each family who participates in a home visiting program that is supported with MIEC funds will be assessed individually, that a service plan will be developed and that accordingly assistance will be provided in accessing needed community services.

Voluntary Participation. This has been a hallmark of home visiting programs in Illinois from the inception of Parents Too Soon in the early 1980s and the inception of Healthy Families Illinois in 1997. Voluntary participation was explicitly addressed in the original implementation plan for Healthy Families Illinois in 1995. This commitment will continue for home visiting programs supported by the MIECHVP.

Maintenance of Effort. The Illinois Department of Human Services will comply with the Maintenance of Effort requirement presented in Section 511(f), of Title V of the Social Security Act for the MIECHVP.

Priority Populations. The Illinois Department of Human Services assures that priority will be given to serving families from the priority populations identified in Section 511(d)(4), Title V of the Social Security Act.

Working with National Model Developers. The IDHS, the ISBE and the Ounce of Prevention Fund have long-standing relationships with Prevent Child Abuse America, Healthy Families America and the Parents as Teachers National Offices. The faculty of the Illinois Birth To Three Institute has been certified by at least one of these national program offices as trainers in the Healthy Families America or Parents as Teachers models. All of the curricular materials used in training local home visiting staff have been obtained from or approved by the national offices. All three organizations will maintain these working relationships and obtain additional technical assistance as necessary throughout the MIECHVP.

The Midwest Program Developer for Nurse-Family Partnership has been actively involved in both Strong Foundations and the Strong Foundations Partnership and, along with the Nurse-Consultant from the NSO, is prepared to provide technical assistance and clinical support to new or expanded Nurse-Family Partnership programs in the MIECHVP target areas. Similarly, Advocate Health Care, the lead organization for Healthy Steps in Illinois, is represented on the Task Force and is prepared to assist family practice or pediatric clinics to implement the full Healthy Steps model. Finally, the Region V Office of Head Start is represented on the Task Force's Executive Committee and is available to provide technical assistance to Early Head Start programs.

Training (Obtaining Curricula). The Ounce of Prevention Fund Training Institute's schedule for April, May and June 2011 may be used to illustrate the volume and variety of training available to home visiting and related early childhood programs. The topics to be presented during those three months are listed below with regard to specific program models. The training schedule is available on line at http://www.opftrainingcenter.org and http://pi.opftrainingcenter.org. As illustrated below, Illinois has a well-established mechanism to provide initial and ongoing training for many evidence based program models, including HFI, PAT, NFP, Healthy Steps, and EHS.

Initial Training for HFI and PAT

- Healthy Families America Core Training: Family Assessment Workers
- Healthy Families America Core Training: Family Support Workers
- Parents as Teachers Foundational and Model Implementation Training
- Ages and Stages Questionnaire-3
- Introduction to Mandated Reporting Online
- Functional Hearing and Vision Training

Ongoing Training for HFI, NFP, and PAT

- Adolescent Development and Parenting
- Ages and Stages Questionnaire: Social Emotional
- Bilingual Family Support in Spanish
- Community-Based Family and Neonatal Assessment

- Doulas Inservice
- Early Childhood Development: Infancy
- Heart To Heart Curriculum Training (this training addresses the impact of child sexual abuse)
- Home Visiting Program Strategies
- Individual Family Support Plan Online
- Infant Mental Health Learning Group
- Infant Mental Health Network for Direct Service Staff
- Parents as Teachers Supervisors Network
- Parent Group Facilitation and Dynamics I
- Parent Group Services Practice Network
- Perinatal Depression Screening
- Promoting Literacy and Language Development in Families
- Reflective Supervision
- Self-Sufficiency and Family Life Skills
- Strategies for Father Involvement in Home Visiting
- Strengthening Families: Protective Factors
- Strengthening Families: Understanding Trauma and Children Exposed to Violence
- Strong Foundations: Domestic Violence
- Strong Foundations: Perinatal Depression
- Strong Foundations: Substance Abuse
- Supervisors Special Topics
- Using Videos to Enhance Family Support I and II

Initial and Ongoing Training for EHS

- Adolescent Development and Parenting
- Ages and Stages Questionniare-3
- Ages and Stages Questionnaire: Social Emotional
- Early Childhood Development: Infancy
- Functional Hearing and Vision Screening
- Healthy Families America Core Training: Family Assessment Workers
- Healthy Families America Core Training: Family Support Workers
- Heart To Heart Curriculum Training
- Home Visiting Program Strategies
- Individual Family Support Plan Online
- Parent Group Facilitation and Dynamics I
- Perinatal Depression Screening
- Reflective Supervision
- Self-Sufficiency and Family Life Skills

Curriculum and materials for NFP are provided by its National Service Office in accordance with the NFP-NSO proprietary contract. The curriculum and materials for Healthy Steps are provided by Healthy Steps Chicago. Early Head Start programs will obtain training from national and

local organizations. Early Head Start programs using the Born To Learn curriculum will obtain training from the Illinois Birth To Three Institute. This approach to training is required by the developers of these models. These national organizations have not established or supported the development of state-level training infrastructures.

Staffing at the State Level. Three state-level positions are included in the staffing plan for MIECHVP: the Project Director, the Evaluation Coordinator and a Fiscal Manager. The status of hiring each position is summarized below.

The Strong Foundations and Strong Foundations Partnership Project Director, Ms. Teresa Kelly, began work in the Governor's Office of Early Childhood Development on May 15, 2011. Her job description was included in the original Strong Foundations Partnership proposal submitted in July 2010. Her resume may be found in Appendix 2.

The Evaluation Coordinator will have a strong back ground in both program and evaluation. The position will create a review process to evaluate the effectiveness of home visiting programs on a community and state level. The Evaluation Coordinator will stay current on home visiting related research being done by other states or at a national level and assist in applying the findings to Illinois' own program innovation and quality improvement efforts. The position may be filled by either state staff or through a contract depending on our hiring options at the time.

The position of Fiscal Manager is being established in the IDHS' Division of Community Health and Prevention. The position will use the "Advanced Accountant" payroll title and will be filled competitively following the requirements of the State's collective bargaining agreement with the American Federation of State, County and Municipal Employees.

The position of MIECHVP Data Manager is being established in the IDHS' Division of Community Health and Prevention. The position will use the "Public Service Administrator Option 6" payroll title and will also be filled competitively following the requirements of the state's collective bargaining agreement. A position description may be found in Appendix 3.

Achievement of Outcomes. The Home Visiting Task Force fully expects that the evidence-based home visiting models selected for implementation through this initiative, along with the ancillary services that many participating families will require, will achieve the outcomes listed in Section 511, Title V of the Social Security Act.

State Support During Implementation. The Project Director will convene a "State Level Implementation Team" to support program activities in the Target Areas. The team will include program management and regional staff from IDHS, ISBE and the Ounce of Prevention Fund, representatives from the national model developers and representatives from the Target Areas. The team will meet regularly (at least monthly for the first six months) to address any problems that emerge during program implementation that require coordination of policy between funding agencies, funders and national models or that affect program operations in all of the Target Areas. The team will form smaller work groups as necessary to address these issues and these work groups will invite other participants as necessary. The team will direct issues to the Home Visiting Task Force and its Executive committee as necessary. The team's overall purpose is to

ensure that each model supported by MIECHVP funds in the Target Areas is operated with fidelity.

The Division of Community Health and Prevention assigns a Community Support Services Consultant (CSSC) to each provider it funds. The CSSC serves as the provider's primary liaison to the Division. CSSCs are assigned geographically, so that all of the agencies in a community which receive grant funds from DCHP are monitored by the same CSSC. At the community level, this enables CSSCs to promote communication and coordination among providers.

CSSCs conduct orientation site visits with new service providers, new Executive Directors and new program supervisors. The agenda for this visit includes a review of DCHP's structure and its place within IDHS, the Division's fiscal grant management requirements, the program requirements specified in the provider agreement and an overview of the other organizations in the community which receive funds from the Division and the services they provide. The orientation visit is scheduled to occur within six weeks of receiving funding from DCHP. Established providers that are receiving funds for new services receive an abbreviated visit which focuses on contract requirements and other pertinent information related to program services.

As the primary liaison between community service providers and the Division, CSSCs remain in regular contact with the agencies they are assigned to and with program managers within DCHP. This ensures that provider concerns are brought to the attention of program managers, that technical assistance is provided quickly, and that program requirements are communicated to providers and implemented. The assigned CSSC will have at least monthly contact with each MIECHVP-funded provider during the first year of program operation. The CSSCs, MIECHVP project staff and representatives from the model developers will regularly exchange information about program implementation and operation in order to minimize duplication of effort and maximize the impact of available support and technical assistance. On-going monitoring of these programs is discussed later in this section.

Local Level

Community Engagement For Implementation and On-going Administration. The Executive Committee will create two more structures to ensure that local home visiting programs are operated with fidelity to national models, First, the Birth to Three Training Institute will convene a learning community comprised of supervisors and home visitors from each of the home visiting programs in the Target Communities. This group will meet regularly to discuss implementation and program operation problems, develop solutions and share lessons learned through the implementation process. This structure will ensure a regular exchange of information among the programs in the Target Areas.

Second, a collaborative team will be formed within each Target Area. Implementation and operation of MIECHVP will be an important focus for each of the existing early childhood collaborations in these communities. The IDHS CSSC assigned to each Target Area will support and work with local early childhood leadership to regularly convene the home visiting programs

and, as necessary, ancillary service providers in each Target Area. These meetings will provide a mechanism to identify and resolve problems with outreach, enrollment, service coordination and information exchange. This level of collaboration will be sustained throughout the process of implementation and program operation through regular contact between Partnership staff and the local collaboration. Staff from the Partnership organizations will draw on their experience with local collaboration building, such as the AOK Networks, as well as tap into the systems development and collaboration building expertise convened and coordinated through the Early Learning Council's Community Systems Development Workgroup..

Selection of Sub-awardees. The Executive Committee plans to accept one collaborative work plan and a related budget from each community. The providers in each target community will prepare and submit a budget and program plan to address each of the topics identified below. (This is not meant to imply that a fiscal intermediary will be identified in each Target Area.) Each community's response will be judged against the model developer's requirements. This will reinforce the collaboration demonstrated during the community panel presentations that were used to select the final target areas. To ensure that the program is designed at the community level to implement models with fidelity and to achieve national benchmarks, each work plan will address the following requirements:

Home Visiting

The following characteristics are meant to describe the operation of a home visiting program regardless of model. Communities will be asked to describe their plans for operation of each home visiting program using this framework.

- *Strategy for Identifying Families*. The targeted communities[18] proposed approaches for identifying families in their presentations. Their final work plans will elaborate on these proposals.

- *Model*. The models selected by each community were presented in Section 3. Communities will be asked to describe how the home visit will incorporate "The Principles and Premises of Family Support Practice"[19] and the Strengthening Families Illinois Protective Factors.[20] Communities will also be asked to describe how their proposed model reflects a trauma-informed approach to services,[21] including screening for the effects of childhood trauma, appropriate referrals and conducting home visits with an appreciation of the serious impact of exposure to trauma for parents, children and other family members.

- *Minor Adaptations*. Communities will be asked to describe any modifications to the evidence model which they believe are necessary to adapt it to the needs of their target

[18] Throughout this section, "community" should be understood to mean the group of service providers that prepared the community's presentation to the selection committee.
[19] Family Support America. (1996). Guildelines for Family Support Practice Chicago: Family Resource Coalition.
[20] Protecting Children by Strengthening Families: 6 Ways to Keep Families Strong Through Early Care and Education. http://www.strengtheningfamiliesillinois.org/downloads/6_Factors.pdf
[21] Harris, M. and Fallot, R.D. (Eds.) (2001) Using trauma theory to design service systems: New directions for mental health services. San Francisco, CA, US: Jossey-Bass.

population. IDHS staff will work with national model developers to ensure that these adaptations will not alter any of the core elements of each model. (The NSO does not authorize any variances within the first full year of implementation. Then any variances would require a variance plan designed in collaboration with the NFP Nurse Consultant.)

- *Target Audience*. Communities will be asked to specify their target populations and indicate which of the priority populations identified in Section 511(d)(4) of Title V of the Social Security Act will be included. The definition will also include a specification of family circumstances (maternal gravidity, family income, the child's age [including intake during pregnancy], risk for maltreatment and other characteristics required by the model's specifications. The specified target population must conform to the requirements of the selected model.

- *Number to be Served*. The community will be asked to estimate the number of families to be served each year and explain their procedure for creating this estimate. The estimate will be compared with the selected model's guidelines for caseload size and the applicant's proposed staffing plan.

- *Time to Meet Caseload*. Communities will be asked to estimate the amount of time that will be required to meet maximum caseload. The caseload and staffing plan will be compared to national model requirements.

- *Strategies to Minimize Attrition*. Communities will be asked to describe strategies for minimizing attrition after initiation of services.

- *Voluntary Participation*. Communities will be asked to assure that services will be offered on a voluntary basis.

- *Persistent Outreach*. Communities that have selected Healthy Families Illinois will be asked to describe their approach to "creative" or persistent outreach as required by the national model. Communities that have selected another model may propose to include this element as well.

- *Service Intensity*. Communities will be asked to specify the frequency of home visits and the criteria for increasing or decreasing the frequency of home visits. Their responses will be compared with the guidelines for each model.

- *Cultural Competence*. Communities will be asked to describe the approaches that they will take to ensure that home visitors, curricula and other aspects of the program will demonstrate cultural competence.

- *Content of the Home Visit*. Communities will be asked to describe the content that will be included in a home visit. This will include content to support parents, promote parent-child interaction and promote child development. They will also be asked to specify that visits will be conducted one-on-one between the home visitor and the parent(s) and that visits will be

conducted in the home setting. The proposed content will be compared to the requirements of each model developer.

- *Limited Caseloads*. Communities will be asked to describe their policy for limiting caseloads of home visitors and the mixture of families at various levels of program experience and risk that can be served by one home visitor. This plan will be compared with the model developer's guidelines.

- *Home Visitor Characteristics*. Communities will be asked to present a staffing plan and describe the characteristics that will be considered in selecting home visitors, including education, professional licensure, education and work experience. The proposed plan will be compared with the model developer's guidelines.

  The staffing plan is expected to include a program coordinator (who, depending on program scale, may also serve as the supervisor), a supervisor, home visitors, support staff (for data entry and other purposes) and other staff roles, depending upon the program model.

- *Training*. Communities will be asked to present a plan for obtaining training from national, state and local sources, depending upon the selected model. This will be compared to the requirements of the selected model.

- *Reflective Supervision*. Communities will be asked to present a plan for training supervisors in reflective supervision and for ensuring that supervisors continue to practice this approach.

- *Groups*. Communities that select Parents as Teachers will be asked to present a plan for supplementing home visits with group meetings. The plan will be compared to PAT's Essential Requirements to ensure that the proposed plan meets model specifications.

- *Agency Experience and Fiscal Condition*. Community organizations will be asked to discuss their experience in operating home visiting or other family support programs for families who have young children or may be expecting a newborn. They will also be asked to discuss their current fiscal condition.

- *Community Advisory Board*. Communities that select Nurse Family Partnership, Parents as Teachers or Early Head Start will be asked to describe the composition and structure of their community advisory boards for these models. Communities may propose the integration of this group with the early childhood collaborative, or describe how an early childhood collaborative may serve this purpose. Communities that select other models may propose to develop a community advisory board as well.

- *Quality Assurance and Continuous Quality Improvement*. Communities will be asked to present a plan for quality assurance and continuous quality improvement. The plan should describe the frequency with which a quality assurance activities will be conducted as well as who within the applicant organization will participate in this process.

Communities will be informed in the instructions that they will be expected to participate in the data collection, program monitoring and continuous quality improvement activities of the model developer and the Illinois Department of Human Services.

Communities will be informed in the instructions that home visiting programs will be required to complete the quality assurance requirements of the national model, including requirements to affiliate with the national model developer's organization and to complete any long-term quality assurance process, such as accreditation or commendation.

Communities will be informed in the instructions that they will also be required to participate in the collection of data required to measure progress on the constructs which will be used to measure the national benchmarks. Communities will also be expected to include this information in their own quality assurance and continuous quality improvement procedure.

Linkages to Primary Care and Other Services.

Communities will be required to describe the way in which they will implement the assessment, referral and service coordination as a part of the home visiting program and to assure that families will receive an individualized assessment.

Communities will be required to identify the organizations they will be partnering with to ensure that participating families have a source of primary medical care (including family practice, internal medicine and obstetric and gynecological care for adults and pediatric care for children). The Illinois Department of Healthcare and Family Services has made a substantial commitment to the use of medical homes for preventive and primary care and to coordinate access to specialized medical care for children who are covered by All Kids. Home visiting programs will be informed of and encouraged to work closely with each family's medical home. Communities will describe the relationship between home visiting programs and other service providers, including mental health, substance abuse treatment, domestic violence, parental developmental delay or disability, homelessness and limited English proficiency (to address all of Illinois' high-risk populations), and other agencies that serve families who have young children or are expecting a newborn.

All participating children should be screened for developmental delay and referred when necessary for services under Part B or Part C of the Individuals with Disabilities Education Act.

Communities will be encouraged to submit written memoranda of understanding with community-based service providers to ensure that families will have access to these services. Communities will be asked to provide these memoranda before service provision begins. Communities may propose a planning period to take the time required to negotiate these agreements.

Universal Screening and Coordinated Intake. The Executive Committee will work with the home visiting programs and other early childhood service providers in each Target Area to develop and

then test one or more approaches to implementing this component. The system is expected to have the following characteristics:

- *Universal Screening* – The Executive Committee and the local early childhood collaborative will consider the working relationships that have been established with organizations that are presently serving large numbers of families who may be eligible for home visiting, such as family planning clinics, prenatal care providers, hospital obstetric units, family practice and pediatric practices, providers of the Special Supplemental Nutrition Program for Women, Infants and Children, and similar programs. The planning process will also consider the screening instrument(s) that should be used and the protocol for administering, scoring and interpreting them.

- *Coordinated Intake*. The Executive Committee expects that the scope of this function will begin with home visiting and later expand to coordinate intake among all early childhood services in a community. The plan will consider the distribution of eligible families among home visiting programs in the community and the establishment of formal linkage agreements or Memoranda of Understanding with each of the home visiting programs. As this function expands, additional linkage agreements with concluded for each service that is to be coordinated through this intake system.

- *Staffing*. The plan will include the education, experience, licensure and training required for the personnel who will be conducting screening and referral activities.

- *Information System*. The plan will also identify and describe the information system that will be used to support the screening and intake function and ensure that it will be compatible with the information system used by the home visiting program.

- *Privacy and Confidentiality*. Any approach to screening and intake must have policies and procedures for maintaining privacy and confidentiality of information that comply with the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act as well as state privacy laws and regulations.

Early Childhood Collaboration

Early childhood collaborations are in various stages of development in the target areas. Through the State Early Childhood Comprehensive Systems grant and the All Our Kids Networks, IDHS will provide technical assistance and include the network representatives from these communities in training opportunities to strengthen early childhood collaboration. Communities will be asked to present a plan for strengthening the network over the course of the MIECHVP initiative.

Budget. Communities will be asked to submit an integrated budget for all of the home visiting programs that will be expanded with MIECHVP funds. They will be asked to identify the amount of funds allocated to each model and identify staff and other costs that will distributed across components.

Implementation Work Plan and Timeline. Communities will be asked to submit an implementation work plan and timeline which identifies major activities and milestones for program implementation and operation. The initial year will be divided into a *planning period* and a time point for *service initiation*. The planning period will last as long as is necessary for the community to establish formal referral relationships with providers of core ancillary services, to prepare the universal screening and coordinated intake function and to recruit, hire and train the home visiting program staff. Once these things have been accomplished, communities will be authorized to initiate services.

Logic Model or Theory of Change. The final component of the local implementation plan will be a logic model or theory of change that will summarize the implementation of project components. Templates such as the W. K. Kellogg Foundation's "Logic Model Development Guide" will be recommended to potential Communities.

The Executive Committee will review the work plans and budgets and negotiate final awards with agencies in each community. IDHS will follow established procedures to award funds to selected sub-awardees.

IDHS plans to release a third RFP to identify a contractor to administer and score the standardized questionnaires that will be used to measure several constructs, especially those related to child development. This RFP will also request information on staff recruitment, selection and training to ensure that this aspect of data collection can begin at the same time that home visiting services.

Recruit, select and hire staff. One of the first tasks for communities will be to recruit, select and hire the staff according to the plan identified in their proposals and approved by the Partnership. This process will be monitored by DCHP's assigned CSSC.

Train staff. As soon as practical after hiring, local project staff will complete the training required by the model developer. This training is conducted by the Illinois Birth To Three Institute for HFI programs, the Parents as Teachers State Office for PAT programs, by Advocate Health Care for Healthy Steps programs, by the National Service Office for NFP programs and through national and local sources for the Early Head Start program. Attendance at training will be monitored by the assigned CSSC.

Establish Linkages. The establishment of linkages to other community organizations for referrals of new families and to link participating families to ancillary services is an essential aspect of program implementation. The CSSC assigned to the implementing agencies in a community will both monitor and facilitate the establishment of these relationships.

Coordination with Ancillary Services. The availability of ancillary services (for mental health, substance abuse, domestic violence, homelessness and early intervention) in the target communities was presented in Section 1.

Identification and Recruitment of Participants. Each community's plan for identifying and recruiting participants was presented in Section 1.

Begin data collection. Shortly after funds are awarded to the implementing agencies, DCHP will introduce the software that will be used to gather information on MIECHVP-funded services. The software will be introduced through training of local program staff. The training will be scheduled to occur so that data collection may begin when services are initiated.

Ongoing Monitoring

Monitoring , Assessing and Supporting Implementation with Fidelity. Please refer to the discussion of assessing, monitoring and supporting the operation of new or expanded home visiting programs with fidelity to the model developer's guidelines in Section 3 of this Implementation Plan.

Data System for Continuous Quality Improvement (CQI). The IDHS is going to procure a "commercial, off-the-shelf" data system to collect the information required for measurement of the constructs and for continuous quality improvement. The unique needs and limited initial scope of MIECHVP, the cost of software enhancement or development and the need to have a data collection system implemented quickly make this a cost-effective approach. The State of Illinois has established a formal approach for the development or procurement of software. The staff of IDHS' Division of Community Health and Prevention has experience with this procedure. The disadvantage of this process is that it may require duplicate reporting by the home visiting programs. Every effort will be made to establish agreements to provide to or obtain data from the model developers in order to minimize this burden on local programs. Information on the data sharing agreements that have been established and are still required among IDHS, IDHFS, the Illinois Department of Public Health and DCFS is presented in Section 5.

Number of Families to be Served. Since the final number of programs that will be expanded or implemented through MIECHVP won't be known until the competitive selection process has been completed, it is difficult to precisely estimate the number of families that will be served. A rough estimate may be derived by using the average cost of $4,160 per family per year for three of the four models Illinois has chosen.[22] The proposed budget for FFY'10 MIECHVP funds allocates $1.4 million for the operation of programs. As a result, the program expects to serve 330 families per year.

Timeline to Reach Maximum Caseload. Each of the evidence-based models has slightly different requirements for a local program to reach maximum caseload. For HFA, it is expected that a new home visitor will be at his or her maximum caseload within no less than six months of hire and no more than 12 months of hire.[23] Healthy Steps enrolls and follows all newborns between birth and three years-of-age in a given practice. On average, Healthy Steps Specialists will meet 100 newborns per year, or between eight and nine per month. Their total caseload is generally between 250 and 300 families.[24] NFP nurse home visitors are expected to achieve full

[22] Daro, Deborah, Chapin Hall Center for Children. Personal correspondence, April 7, 2011, citing published reports from the model developers.
[23] Strader, Kathleen. Ibid.
[24] Berry, Anita. Ibid.

caseloads between the ninth and twelfth month during the first year of program operation. The intermediate targets are as many as 10 participants within three months and as many as 15 participants within six months.[25] For PAT, first-year parent educators are expected to provide no more than 48 visits per month, while experienced parent educators can provide up to 60 visits per month. Parents as Teachers does not have a set time to reach full capacity, as that varies based on whether the organization has a ready pool of eligible families, the other services available in the community, and the visibility and existing community collaborations that the sponsoring organization has.[26]

Minimizing Attrition Rates. Each of the evidence-based models we have chosen for implementation recommends slightly different strategies for minimizing attrition rates. Consultation with model developers revealed an emphasis on the establishment of supportive relationships with participating families as an important strategy for minimizing attrition. Healthy Families America programs emphasize "creative outreach strategies."[27] Healthy Steps emphasizes the importance of linking patients to their medical home, which allows them to continue to see the same primary care provider for up to 18 or 21 years or, in the case of family medicine, into adulthood.[28] NFP uses motivational interviewing and reflective practice as tools within the context of cultural responsiveness and inclusivity to reduce attrition.[29] The Parents as Teachers Model Implementation Guide and Training include a focus on recruitment and retention of families, and specifically emphasize strategies for successful retention and engagement of vulnerable families. The number of families that exit the program each year are tracked, along with the reasons for the exit. Affiliates are expected to review and report their data on attrition annually to the national office.[30] This aspect of program operations can also be examined through Continuous Quality Improvement procedures. All home visiting programs in Illinois will be encouraged to employ all of these strategies to reduce attrition.

Clinical Supervision and Reflective Practice. As developed by Heller and Gilkerson (Heller & Gilkerson, 2009) and others, reflective supervision "Is a collaborative relationship for professional growth that improves program quality and strengthens practice" and that "builds the capacity of individuals and organizations by cherishing strengths and partnering around vulnerabilities." (Dunham, 2011). Reflective supervision in practice requires "regularity" (structured, repeated experiences), "reflection" (using open-ended questions and maintaining a non-judgmental orientation in order to look at all the facets of the home visitor's relationship with the family) and "collaboration" (to pursue a shared understanding of the situation, explore the use of power and to create new solutions). For many years, the Illinois Birth To Three Institute has been training supervisors of local home visiting programs to use this approach. It is now the generally accepted standard of practice in Illinois Home Visiting programs.

Anticipated Challenges. Please refer to the discussion of the challenges anticipated in maintaining fidelity in Section 3 of this Implementation Plan.

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[25] Anderson, Jeanne. Ibid.
[26] Eldredge, Clare. Ibid.
[27] Strader, Kathleen, Healthy Families America. Personal correspondence, April 22, 2011.
[28] Berry, Anita, Advocate Healthcare. Personal correspondence, April 22, 2011.
[29] Anderson, Jeanne, Nurse-Family Partnership. Personal correspondence, April 22, 2011.
[30] Eldredge, Clare, Parents as Teachers State Office. Personal correspondence, April 26, 2011.

Section 5: Plan for Meeting Legislatively-Mandated Benchmarks

This section presents Illinois' plan for collecting and analyzing data to ensure that the initiative is making progress in each of the federal benchmarks. The state's approach to ensuring model fidelity through continuous quality improvement is presented in Section 7. The plan for continuous quality improvement includes the plan for collecting data on participant demographic and socio-economic characteristics as well as the collection of data on service utilization. The plan for selection of software to collect data on the constructs and measures of program fidelity was presented in Section 4.

Data Collection and Analysis Plan

The plan for collecting data on each construct is presented in a series of tables following the narrative analysis plan. A definition of improvement is presented for each construct. Nearly all of them are stated as improvements over time, whether that is achieved by increasing a protective factor (e.g., use of prenatal care) or decreasing a risk factor (e.g., prenatal substance abuse or child maltreatment.) Fundamentally, each construct will be measured for the appropriate group of program participants (e.g., mothers, children, families) during a reporting period. Change in the desired direction from one reporting period to the next constitutes improvement or progress on the construct and, if there is progress on more than half of the constructs for a benchmark, progress on the benchmark as well.

In general, reporting periods are years and the occurrence of events in one year is compared to the occurrence of the same event in a prior year. The data for many of the constructs are collected by self-report from the participant or the home visitor. In these cases, reporting periods can be much shorter, e.g., quarter years, and the data can easily be analyzed and used for continuous quality improvement as well as outcome reporting.

The denominators for most of the measures are persons who are actively participating in home visiting. Therefore, it is likely that each measurement will include people who were included in a previous measurement as well as new enrollees. The measurement of dynamic attributes, such as child development, employment, income and health insurance coverage, are measured at specific points in a family's participation (e.g., after one year of program participation) or at a fixed point in the reporting process (e.g., on the last day of the reporting period) in order to make the results comparable over time. This does introduce some inaccuracy, since the family's status at the time of measurement may have changed immediately before or may change immediately after measurement. This procedure does ensure that the numerator used to measure each construct is a subset of the denominator. The measurement of fixed attributes (those associated with an event such as the delivery of a pregnancy or the age of a child) will compare persons who meet a standard (e.g., obtain an "adequate" amount of prenatal care or score in the normal range on a test of development) to all persons from whom the data could be collected (all women who have delivered a pregnancy or all children who have reached a certain age) in the reporting period. This will maintain independence in these observations.

Whenever possible, data will be extracted from administrative data sets and matched to records for program participants. Four primary administrative data sets are used: the IDHS' Cornerstone management information system for data on WIC participants; birth certificates from Illinois' vital records, the Illinois Department of Children and Family Services' Statewide Automated Child Welfare Information System (SACWIS) and the Illinois Department of Healthcare and Family Services' Medical Data Warehouse. Since these data are generally not available in a timely manner or the limited initial number of home visiting participants makes frequent matching impractical, many data items are initially collected by self-report, to be replaced at a later time when information from these administrative data sets becomes available.

The Illinois Department of Human Services, the Illinois Department of Public Health (Illinois' vital registrar) and the Illinois Department of Healthcare and Family Services presently have an extensive memorandum of understanding which grants shared access, within some limits, to vital records, the Medical Data Warehouse and the Cornerstone management information system. Through this agreement, IDHS' Cornerstone management information system also contains information on children who have been placed in substitute care. This is, however, a minority of the children who have been determined to be abused or neglected and does not include children who have been reported to the Department of Children and Family Services but found not to have been maltreated. A separate data sharing agreement to obtain these data is under development.

The use of data sets for public benefit programs, such as WIC or Medicaid, creates the possibility that critical information will not be available for all program participants. Since the program is targeting low-income communities and both of these programs enjoy a high rate of participation in general (more than half of the states births are served by each program), a high rate of participation in these programs is expected among home visiting participants and the risk of incomplete data sets is minimized. However, this is an aspect of data quality which the Executive Committee will continually examine.

Several of the constructs will be measured through the application of standardized measures. Rather than expect home visitors to collect these data, an external organization will be used. This will ensure that the interviewers meet the qualifications and have the training required to administer the measures. It also ensures that the data will be collected by someone independent of service delivery. The IDHS used this procedure successfully in an early evaluation of the Healthy Families Illinois program.

Table 4 identifies the various items that will be obtained through interviews or direct observations of program participants. In most cases, items will be collected at the time of enrollment (either pre-natal or following the infant's birth); at birth (regardless of point of enrollment); 6-months post birth; 12-months post birth; 24-months post birth; 36-months post birth; 48-months post birth; and 60-months post birth. The number of assessments on any individual participant will depend on the planned duration of the program (NFP is provided for two years while HFA is offered for five years) and the participant's length of program engagement. Participants who leave the program prior to the end of planned services will be assessed to the extent at the point services terminate.

In addition to indicating those items that will be collected during these participant assessments, the table also indicates domains or indicators that will be tracked through state administrative records, program case records and/or staff assessments.

Addressing all of the indicators included in the "coordination of service referral" domain will require an annual survey of those local agencies to which the home visiting program obtains referrals as well as those agencies to which they commonly refer program participants for additional assistance. The core topics that will be addressed during these interviews include:

- The existence of a memorandum of understanding between the home visiting program and this agency or other mechanisms used to facilitate the referral process
- The extent to which the agency has interacted with the home visiting program around a client specific function such as the number of home visiting participants that have been referred to the agency; the percentage of these referrals who became active program participants; and the frequency of participant case planning meetings.
- The extent to which the agency has worked with the home visiting program and other local partners around infrastructure issues such as staff training, advocacy, resource sharing, or program planning.

Once the data are collected for each reporting period, they will be analyzed by calculating the percentages described in the following tables for each construct. The results for each reporting period will be compared with the results from the prior reporting period to determine whether change has occurred in the desired direction. Data will also be analyzed in subsets, including a subset for each model, each community, and participant's age (for children, on measures of development and the occurrence of maltreatment). Additional subsets will be created at the local level for continuous quality improvement, including analysis by home visitor and individual participant.

Table 4
Summary of the Data Collection Strategy for Constructs and Benchmarks.

Benchmark	Construct	Self-Report	Standardized Measure	State Administrative Records	Program Records/Staff Observations
Maternal and newborn health	Prenatal care (Kotelchuck Index)	X		Vital Records	
	Prenatal ATOD use	X	DAST	WIC	
	Use of birth control	X			
	Inter-pregnancy interval	X		Vital Records	
	Maternal depression		Edinburgh		
	Breastfeeding (6 mo. Duration)	X		WIC	
	Well-child care	X		All Kids data	
	Maternal health insurance	X		Medicaid data	
	Child health insurance	X		All Kids data	
Child injury	ER visits mother	X		Medicaid data	

and CAN	ER visits child	X		All Kids data	
	Training on key prevention concepts				Case records
	Incidence of child injury	X		Medicaid data	
	Reports of suspected maltreatment			DCFS	
	Confirmed reports of maltreatment			DCFS	
	First-time confirmed maltreatment			DCFS	
Improved School Readiness	Parenting support for learning/parent child relationship		PICCOLO		Home visitor observation
	Knowledge of child development		KIDI		
	Negative parenting style		CTS-PC		
	Parent emotional well-being		PSI		
	Child development		ASQ3		
	Child approach to learning/emotional well-being		ASQ:SE		
	Child height/weight			WIC	
Domestic Violence	Participant screened for domestic violence				Case records
	(if needed) access to DV services				Case records
	(if needed) development of safety plan	X			
Family Economic Self-Sufficiency	Household income (all sources)	X			
	Employment status (hours worked)	X			
	Educational level	X			
	Enrollment in continuing education/training	X			
	Health insurance status	X		Medicaid, All Kids	
Coordination of service referrals	Assessment for service needs				Case records
	Referrals for needed services				Case records
	Completed referrals				Case records

Several steps will be taken to safeguard the privacy of program participants and protect the confidential nature of the information provided to IDHS for analysis. First, IDHS will require that state and local staff that have access to the data sign an agreement acknowledging the confidential nature of the information and the disciplinary actions that can be taken for unauthorized disclosure. Second, IDHS will require that the software package use several levels of password protection to limit the amount of information that state and local users can access. Third, participants will be asked to sign a statement of informed consent for the collection of project-related data and release of information provided to other sources (e.g., other state agencies). Fourth, the data collection contractor will ask participating families to sign a statement of informed consent at each data collection interview. Both consent forms will be translated into Spanish. Fifth, state staff will not publish data about individual participants, nor report on rates with fewer than 10 observations in the numerator in order to avoid unintended identification of project participants. Sixth, all of the consent forms, the analysis plan and the confidentiality procedures will be submitted to an Institutional Review Board for review and approval before use.

The IDHS has contacted and intends to work with the Western Institutional Review Board, a private and independent institutional review board located in Olympia, Washington. According to its web site:

> "Western Institutional Review Board (WIRB) is duly constituted, has written procedures for initial and continuing review of clinical trials; prepares written minutes of convened meetings, and retains records pertaining to the review and approval process; all in compliance with requirements of FDA regulations 21 CFR Parts 50 and 56, HHS regulations 45 CFR 46, and International Conference on Harmonization (ICH) E6, Good Clinical Practice (GCP), as applicable. WIRB is registered with OHRP/FDA; our IRB registration number is IRB00000533, parent organization number is IORG0000432."[31]

IDHS has worked with this organization on several projects. Funds for this purpose are identified in the project's budget.

IDHS will maintain the quality of the data by selecting a software package which includes within-field and cross-field edit requirements to prevent the collection of spurious data. Data quality will be assured by hiring qualified data management personnel at the state level. At the state level a data analyst will be hired meeting the following requirements: knowledge , skill and mental development equivalent to completion of four years of college; experience in data analysis and report writing as well as knowledge of research principles; and experience with computing technology and software including GIS, statistical packages and spreadsheets. Local agencies participating in the project will be asked to allocate support staff time to data entry.

Several barriers and challenges to the implementation of this data collection plan can be anticipated; some can be avoided. First, acquisition of the data collection software may take longer than expected. However, the project enjoys the support of senior-level management within IDHS as well as the Governor's Office of Early Childhood Development; this level of administrative support should expedite the selection process. Second, recruitment and hiring of the data manager at the state level may be delayed. If this delay is prolonged, IDHS will consider hiring a contractor to perform data analysis. Third, as noted in the tables for several constructs, data from Illinois' vital records system may not be available for analysis for two years following the year in which the vital event occurred. This is due to staffing shortages at IDHS. To compensate for this, participants will be asked to self-report the information used to measure these constructs. Their self-report will be replaced with administrative data when it becomes available. Further, under Illinois law, records of vital events which occur to Illinois residents in another state cannot be disclosed to third parties by the Illinois registrar without the written consent of the registrar of the state in which the event occurred. Previous attempts to secure this consent have been unsuccessful. This problem affects about three percent of Illinois births.

In summary, Illinois' data collection and analysis plan meets the following federal requirements:

- Data will be collected to measure all of the constructs for all of the benchmarks;
- Data will be collected for eligible families who receive home visiting services that are supported by federal MIECHV Program funds;
- Standard measures will be collected across evidence-based home visiting models;

[31] http://www.wirb.com/content/about_compliance.aspx

- Data will be collected from all participating families (rather than from a sample of participating families);
- Data will be extracted from available administrative data systems whenever possible; and
- Data on demographic and socioeconomic characteristics will be collected from each participating individual. At a minimum, these characteristics will include age, sex, race, origin, language, education and income. (Refer to Section 7 for additional detail on this point.)

Tables presenting the data collection strategy for each benchmark begin on the following page.

Benchmark	Improved Maternal and Newborn Health
Construct	Prenatal Care
Measure	Kotelchuck's Adequacy of Utilization of Prenatal Care Index[32]
Improvement is:	Improvement over time in the proportion of women in the cohort* who obtain at least an "adequate"[33] number of prenatal care visits
Metric or Criterion:	Number of women in a cohort who gave birth during the reporting period who began prenatal care in the 1st, 2nd, 3rd or 4th month of pregnancy and received at least 80 percent of the number of prenatal care visits recommend by the American College of Obstetricians and Gynecologists from the time service began until delivery, divided by the number of women in the cohort who gave birth during the reporting period.
Data Collection	
Method	Mother's self-report, replaced by vital records
Already collected?	Yes (the variables examined by the index, month of pregnancy prenatal care began and length of pregnancy are collected).
By?	Self report; IDHS' Cornerstone System for women who participate in WIC or Family Case Management; Illinois' Vital Records system
MOU Needed?	No
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Vital Records for out-of-state births are not available to IDHS without the consent of the birth state's Registrar of Vital Records. This affects approximately 3% of Illinois births.
Justification	Direct measure of the construct
Administered To:	Collected from all women participating in home visiting
Collection Schedule	At program intake and at delivery.
Administered By:	Collected by the home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Data will initially be collected by self report and replaced with data from Illinois' vital records system. Vital records may not become available for matching for two years after the year of birth.

*Women who enrolled in home visiting during a particular time period.

[32] Kotelchuck, M. 1994. An evaluation of the Kessner Adequacy of Prenatal Care Index and a Proposed Adequacy of Prenatal Care Utilization Index. *Am. J. Public Health* 1994;84;1414-1420

[33] "Adequate" is defined by the Index as initiating prenatal care in the first four months of pregnancy and obtaining at least 80 percent of the number of visits recommended by the American College of Obstetricians and Gynecologists for the remaining time between initiation of care and delivery.

Benchmark	Improved Maternal and Newborn Health
Construct	Parental use of alcohol, tobacco or illicit drugs
Measure	Comparing the rate of alcohol and tobacco use at intake with the rate of use at delivery
Improvement is:	A decrease in the rate of use over time.
Metric or Criterion:	Number of women who gave birth during the reporting period who decreased use of alcohol and tobacco during pregnancy or between program enrollment and delivery, divided by the number of women who gave birth during the reporting period.
Data Collection	
Method	Mother's self-report and data collected by WIC
Already collected?	Prenatal alcohol and tobacco use are already collected
By?	IDHS' Cornerstone MIS for WIC participants
MOU Needed?	No.
Reliability	N/A
Validity	N/A
Limitations	Depends on self-report; administrative WIC data limited to WIC participants.
Justification	Direct measure of the construct
Administered To:	Women who are pregnant at the time of program enrollment or become pregnant while participating in the program
Collection Schedule	At program enrollment or beginning of pregnancy and at the time of delivery
Administered By:	Home visitor
Req'd Credentials	None for self-report; WIC data are collected by WIC program staff
Req'd Training	None for self-report; WIC data are collected by WIC program staff
Barriers / Challenges	Will require participant's consent for the substance abuse treatment provider to information about the participant's progress in treatment to the home visiting agency.

Benchmark	Improved Maternal and Newborn Health
Construct	Parental use of alcohol, tobacco or illicit drugs
Measure	Drug Abuse Screening Test (DAST)[34]
Improvement is:	A decrease in prenatal drug use following enrollment compared to previous cohorts.
Metric or Criterion:	Proportion of program participants who gave birth during the reporting period who reported use of drugs during pregnancy divided by the number of women who gave birth during the reporting period.
Data Collection	
Method	Administration of a standardized instrument by an trained interviewer
Already collected?	No
By?	
MOU Needed?	No.
Reliability/Validity	In repeated testing of the DAST with diverse populations, the measure has demonstrated satisfactory reliability and validity scores for use as a clinical or research tool.[35]
Limitations	None noted in the literature
Justification	Tool is relatively short and easy to administer.
Administered To:	Women who are pregnant at the time of program enrollment or become pregnant while participating in the program
Collection Schedule	Collected at time of enrollment and/or time of birth; Collected at 6-months; 12-months post-birth; annually; termination
Administered By:	Data collection contractor
Req'd Credentials	None – Self-Administered
Req'd Training	None – Self-Administered
Barriers / Challenges	Will require participant's consent for the substance abuse treatment provider to information about the participant's progress in treatment to the home visiting agency.

[34] Drug Abuse Screening Test (DAST). Gavin, D.R., Ross, H.E., & Skinner, H.A. (1989). Diagnostic Validity of the Drug Abuse Screening Test in the Assessment of DSM-III Drug Disorders. *British Journal of Addiction*, 84(3): 301-307.

[35] Yudko, E., Lozhkina, O., & Fouts, A. (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. Journal of Substance Abuse Treatment. 32(2): 189-198.

Benchmark	Improved Maternal and Newborn Health
Construct	Preconceptional Care
Measure	Postpartum use of contraception
Improvement is:	An increase over time in the proportion of post-partum women in the program who regularly use contraception
Metric or Criterion:	Number of women in a cohort who gave birth during the reporting period who initiate use of contraception postpartum, divided by the number of women in the cohort who gave birth during the reporting period.
Data Collection	
Method	Mother's self-report
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A
Validity	N/A
Limitations	Depends on Self-report
Justification	Direct measure of the construct
Administered To:	Women in the program who give birth during the reporting period.
Collection Schedule	Within six weeks postpartum
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Participants may not consent to data collection.

Benchmark	Improved Maternal and Newborn Health
Construct	Interpartum Interval
Measure	The proportion of women who have an interpartum interval of at least 18 months
Improvement is:	An increase over time in the proportion of women who have an interpartum interval of at least 18 months.
Metric or Criterion:	The number of women in the cohort who became pregnant while participating in the program, deliver during the reporting period and who have an interpartum interval of at least 18 months, divided by the number of women in the cohort who became pregnant while participating in the program and delivered during the reporting period. The interval is defined as the number of elapsed months between the woman's prior delivery and her most recent delivery.
Data Collection	
Method	Maternal self-report; Illinois vital records
Already collected?	Yes
By?	Illinois Vital Records
MOU Needed?	No.
Reliability	N/A – administrative data
Validity	N/A - administrative data
Limitations	Vital Records for out-of-state births are not available to IDHS without the consent of the birth state's Registrar of Vital Records. This affects approximately 3% of Illinois births.
Justification	Direct measure of the construct
Administered To:	Women who become pregnant while participating in home visiting
Collection Schedule	At the time of delivery
Administered By:	Self-report collected by home visitor; vital records data collected by hospital personnel
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Data will initially be collected by self report and replaced with data from Illinois' vital records system. Vital records may not become available for matching for two years after the year of birth.

Benchmark	Improvement in Maternal and Newborn Health
Construct	Screening for maternal depressive symptoms
Measure	Edinburgh Postnatal Depression Scale (EPDS)[36]
Improvement is:	An increase over time in the proportion of women who are about to or who have recently given birth who are screened for symptoms of depression
Metric or Criterion:	Number of women in a cohort who gave birth during the reporting period who were screened at least once during the third trimester of pregnancy or the first two months postpartum, divided by the number of women in the cohort who gave birth during the reporting period.
Data Collection	
Method	Administration of a standardized questionnaire by a trained interviewer
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability/Validity	Concurrent validity study on British mothers found that a 12.5 cutoff score identified over 80% of new mothers with major depression and about 50% of mothers with minor depression, with a sensitivity value of 67.7%.[37] A study of Spanish mothers using the Spanish version suggest the best cut-off score for this version is 10/11 for combined major and minor depression, with a sensitivity score of 79% and a specificity score of 95.5%.[38]
Limitations	None reported in the literature
Justification	Direct measure of the construct. The metric is consistent with the Medicaid HEDIS measure for postpartum depression, although the Medicaid HEDIS measure includes screening performed up to one year postpartum.
Administered To:	Pregnant women who give birth while participating in home visiting
Collection Schedule	The Edinburgh Postnatal Depression Scale will be administered at least once between the third trimester of pregnancy and the first two months postpartum
Administered By:	Data collection contractor
Req'd Credentials	None- Self-Administered
Req'd Training	None Self-Administered
Barriers / Challenges	Women may not consent to screening

[36] Edinburgh Postnatal Depression Scale (EPDS). Lee, D.T.S. & Chung, K.H., (1999). What should be done about postnatal depression in Hong Kong? *Hong Kong Medical Journal*, 5(1): 39-42; Murray.L. & Carothers, A.D. (1990). The Validation of the Edinburgh Post-natal Depression Scale on a Community Sample. *British Journal of Psychiatry*, 157: 288-290.

[37] Murry, L. & Carothers, A., (1990). The validation oft eh Edinburgh post-natal depression scale on a community sample. British Journal of Psychiatry. 157, pp. 288-290.

[38] Garcia-Esteve, L, Ascaso, C., Ojuel, J. & Navarro, P. (2003). Validation of the Edinburgh Postnatal Depression Scale (EPDS) in Spanish mothers. Journal of Affective Disorders. 75 (1, June), 71-76.

Benchmark	Improvement in Maternal and Newborn Health
Construct	Breastfeeding
Measure	Duration of breastfeeding
Improvement is:	An increase over time in the proportion of women who breastfeed their infants for at least six months
Metric or Criterion:	Number of infants in a cohort who were born during the reporting period who were breastfed for six months, divided by the number of infants in the cohort who were born during the reporting period and were breastfed.
Data Collection	
Method	Maternal self-report; WIC administrative data
Already collected?	Yes
By?	IDHS through the Cornerstone MIS for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
MOU Needed?	No.
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Limited to participants in the WIC program; a high rate of participation in WIC is expected.
Justification	Direct measure of the construct
Administered To:	Collected from women participating in the WIC program
Collection Schedule	Collected during WIC certification
Administered By:	Local WIC programs
Req'd Credentials	Training as a certifying WIC health professional
Req'd Training	Training as a certifying WIC health professional
Barriers / Challenges	Data collection limited to women who are participating in the WIC program.

Benchmark	Improvement in Maternal and Newborn Health
Construct	Well child visits
Measure	Percentage of children participating in the home visiting program who received zero, one, two, three, four, five, and six or more well-child visits with a primary care practitioner during their first 15 months of life, adjusted for the period of program participation.
Improvement is:	An increase over time in the proportion of children who obtain at least five well-child visits before reaching age 15 months.
Metric or Criterion:	The number of children in the program who reached 15 months of age during the reporting period and who obtained at least five well-child visits before reaching 15 months of age, divided by the number of children active in the program who reached 15 months of age during the reporting period.
Data Collection	
Method	Mother's self-report and IDHFS claims data
Already collected?	Yes
By?	Self-report and by Illinois Department of Healthcare and Family Services
MOU Needed?	No
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Limited to All Kids-eligible children. (A high rate of All Kids enrollment is expected.)
Justification	Direct measure of the construct This is the national Medicaid HEDIS measure for use of well-child care by infants
Administered To:	Self-report collected from the parents of participating children; claims collected from health care providers
Collection Schedule	Claims submitted for payment of services rendered to children eligible for All Kids
Administered By:	Self-report by home visitors; claims submitted by health care providers
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Health care providers participating in the All Kids programs in Illinois have two years to submit claims

Benchmark	Improvement in Maternal and Newborn Health
Construct	Well child visits
Measure	Percentage of children who reach age 3, 4, 5 or 6 years during the reporting period who received one or more well-child visits with a primary care practitioner during the reporting period.
Improvement is:	An increase over time in the proportion of children who obtain at least one annual well-child visit.
Metric or Criterion:	The number of children in the program who reached 3, 4, 5 or 6 years-of-age during the reporting period and who obtained at least one well-child visit during the past year, divided by the number of children active in the program who reached 3, 4, 5 or 6-years-of-age during the reporting period.
Data Collection	
Method	Mother's self-report and IDHFS claims data
Already collected?	Yes
By?	Self-report and by Illinois Department of Healthcare and Family Services
MOU Needed?	No
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Limited to All Kids-eligible children. (A high rate of All Kidseligibility is expected.)
Justification	Direct measure of the construct This is the national Medicaid HEDIS measure for use of well-child care by young children.
Administered To:	Self-report collected from the parents of participating children; claims collected from health care providers
Collection Schedule	Claims submitted for payment of services rendered to children eligible for All Kids
Administered By:	Self-report by home visitors; claims submitted by health care providers
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Health care providers participating in the All Kids programs in Illinois have two years to submit claims

Benchmark	Improvement in Maternal and Newborn Health
Construct	Well child visits / Child Access to Primary Care Practitioners
Measure	Percentage of children receiving services from a primary care practitioner.
Improvement is:	An increase over time in the proportion of children enrolled in All Kids who complete one visit per year with a primary care practitioner
Metric or Criterion:	The number of children in the program who completed at least one visit with a primary care practitioner during the past 12 months, divided by the number of children active in the program for at least 12 months.
Data Collection	
Method	IDHFS claims data
Already collected?	Yes
By?	Illinois Department of Healthcare and Family Services
MOU Needed?	No
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Limited to All Kids-eligible children. (A high rate of All Kids eligibility is expected.)
Justification	Direct measure of the construct (This is the national Medicaid HEDIS measure for use of a pediatric medical home)
Administered To:	Claims collected from health care providers
Collection Schedule	Claims submitted for payment of services rendered to children eligible for All Kids
Administered By:	claims submitted by health care providers
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Health care providers participating in the All Kids programs in Illinois have two years to submit claims

Benchmark	Improvement in Maternal and Newborn Health
Construct	Maternal Health Insurance Coverage
Measure	Eligibility[39] for Medicaid, FamilyCare or other health insurance which covers preventive and primary health care
Improvement is:	An increase over time in the proportion of women who have health insurance
Metric or Criterion:	The number of women in the program who have health insurance at the end of the reporting period, divided by the number of women in the program at the end of the reporting period.
Data Collection	
Method	Maternal self-report and Medicaid or FamilyCare eligibility data
Already collected?	Yes, for Medicaid.
By?	The Illinois Department of Human Services; commercial insurance collected by self-report
MOU Needed?	No
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Administrative data limited to women who are eligible for Medicaid or FamilyCare. (A high rate of Medicaid and FamilyCare participation is expected.)
Justification	Direct measure of the construct
Administered To:	Collected from women participating in home visiting
Collection Schedule	At the end of pre-defined reporting periods (e.g., quarterly)
Administered By:	Local offices of the Illinois Department of Human Services, local health departments and local providers of WIC services
Req'd Credentials	None for home visitors to collect self-reported eligibility. Medicaid and FamilyCare eligibility is determined by staff in local offices of the Illinois Department of Human Services. Presumptive eligibility determinations are made by staff of local health departments, WIC providers, community health centers (and federally qualified health centers) and other publicly-funded health care providers.
Req'd Training	None for home visitors to collect self-reported eligibility. IDHS local office staff and Presumptive Eligibility providers complete training conducted by IDHS and IDHFS.
Barriers / Challenges	Limited to coverage provided through the Medicaid and FamilyCare programs.

[39] This means that woman has been determined to be eligible following review of relevant information.

Benchmark	Improvement in Maternal and Newborn Health
Construct	Child Health Insurance Coverage
Measure	Eligibility[40] for All Kids or other health insurance which covers preventive and primary health care
Improvement is:	An increase over time in the proportion of children who have health insurance
Metric or Criterion:	The number of children in the program who have health insurance on the last day of the reporting period, divided by the number of children in the program on the last day of the reporting period.
Data Collection	
Method	Parental self-report and All Kids eligibility data
Already collected?	Yes, for Medicaid.
By?	The Illinois Department of Human Services; commercial insurance collected by self-report
MOU Needed?	No
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Limited to children who are eligible for All Kids
Justification	Direct measure of the construct
Administered To:	Collected from the parents of children who are participating in home visiting
Collection Schedule	At the end of pre-defined reporting periods (e.g., quarterly)
Administered By:	Local offices of the Illinois Department of Human Services, local health departments and local providers of WIC services
Req'd Credentials	None for home visitors to collect self-reported eligibility. All Kids eligibility is determined by staff in local offices of the Illinois Department of Human Services and the Illinois Department of Healthcare and Family Services.
Req'd Training	None for home visitors to collect self-reported eligibility. IDHS and IDHFS staff complete training conducted by IDHS and IDHFS.
Barriers / Challenges	Limited to coverage provided through the All Kids programs.

[40] This means that the child has been determined to be eligible following the collection and review of relevant information.

Benchmark	Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
Construct	Visits for children to the emergency department from all causes
Measure	Proportion of emergency department visits for non-emergency care.
Improvement is:	A decrease over time in the proportion of visits to a hospital emergency department for non-emergency care
Metric or Criterion:	Number of emergency department visits during the reporting period for participating children for non-emergency care (as determined by diagnosis and procedure codes) divided by the number of emergency department visits during the reporting period for participating children.
Data Collection	
Method	Parental self-report and IDHFS claims data
Already collected?	Yes
By?	Self-report and by the Illinois Department of Healthcare and Family Services
MOU Needed?	No.
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Limited to self-report and to visits by children who have health insurance coverage through All Kids. Accuracy depends on self-reported purpose visit and selection of diagnostic and procedure codes by health care providers
Justification	Direct measure of the construct
Administered To:	Collected from hospital emergency departments
Collection Schedule	Self-report collected quarterly during home visits; billing records completed as services are rendered.
Administered By:	Self-report data collected by home visitor; billing records submitted by health care providers
Req'd Credentials	N/A
Req'd Training	N/A
Barriers / Challenges	All Kids enrolled providers have two years to submit claims for payment.

Benchmark	Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
Construct	Visits for mothers to the emergency department from all causes
Measure	Proportion of emergency department visits for non-emergency care
Improvement is:	A decrease over time in the proportion of visits by participating women to a hospital emergency department for non-emergency care
Metric or Criterion:	Number of emergency department visits by participating women during the reporting period for non-emergency care (as determined by diagnosis and procedure codes) divided by the number of emergency department visits by participating women during the reporting period.
Data Collection	
Method	Parental self-report and IDHFS claims data
Already collected?	Yes
By?	Self-report and by the Illinois Department of Healthcare and Family Services
MOU Needed?	No
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Limited to self-report and to visits by women who have health insurance coverage through Medicaid or FamilyCare. Accuracy depends on self-reported purpose visit and selection of diagnostic and procedure codes by health care providers
Justification	Direct measure of the construct
Administered To:	Self-report from participating women; billing records completed by hospitals
Collection Schedule	Self-report collected during home visits; billing records completed as services are rendered.
Administered By:	Self-report data collected by home visitor; billing records submitted by health care providers
Req'd Credentials	N/A
Req'd Training	N/A
Barriers / Challenges	Medicaid- or FamilyCare-enrolled providers have two years to submit claims for payment.

Benchmark	Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
Construct	Information provided or training of participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (i.e. drowning), and playground safety
Measure	Proportion of participating parents who have received information on prevention of child injuries
Improvement is:	An increase over time in the proportion of parents who have received information about prevention of child injuries
Metric or Criterion:	The number of adults participating in home visiting during the reporting period who receive information about safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (i.e. drowning), and playground safety, divided by the number of adults participating in the home visiting program during the reporting period.
Data Collection	
Method	Report by home visitor
Already collected?	No.
By?	N/A
MOU Needed?	No.
Reliability	N/A – administrative records
Validity	N/A – administrative records
Limitations	Enrollment in the program near the end of the reporting period may not leave enough time during the enrollment period to provide all of the information required for this construct.
Justification	Direct measure of the construct.
Administered To:	Collected from home visitor's records of information provided to adult participants.
Collection Schedule	Data recorded following each home visit in which information is provided to a participating adult
Administered By:	Reported by home visitors
Req'd Credentials	None
Req'd Training	In prevention of child injury
Barriers / Challenges	Participants may not consent to data collection.

Benchmark	Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
Construct	Incidence of child injuries requiring medical treatment
Measure	Proportion of children with an injury which requires medical treatment.
Improvement is:	A reduction over time in the rate of injuries requiring medical treatment
Metric or Criterion:	The number of injuries requiring medical treatment (based on diagnosis or procedure code) which occur to participating children during the reporting period, divided by the number of children participating in home visiting during the reporting period.
Data Collection	
Method	Parental self-report and IDHFS claims data
Already collected?	Yes
By?	Self-report and claims submitted by health care providers
MOU Needed?	No.
Reliability	N/A – administrative records
Validity	N/A – administrative records
Limitations	Limited to self-report and to children who are eligible for All Kids.
Justification	Direct measure of the construct
Administered To:	Collected from parents of participating children and by health care providers
Collection Schedule	Self-report to home visitors; health insurance claims submitted at the time services are rendered.
Administered By:	Collected by home visitors; health insurance claims submitted at the time services are rendered.
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Interpretation depends on the accuracy of diagnostic and procedure codes. Health care providers have two years to submit claims for payment from All Kids.

Benchmark	Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
Construct	Reports of suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)
Measure	Rate of reported for suspected maltreatment (allegations that were not "indicated" (The Illinois Department of Children and Family Services' term for a substantiated report of abuse or neglect.)
Improvement is:	A decrease over time in the proportion of children reported for suspected maltreatment.
Metric or Criterion:	The number of children participating in home visiting who were reported for suspected maltreatment during the reporting period, divided by the number of children participating in home visiting during the reporting period.
Data Collection	
Method	Matching participant data to unsubstantiated reports of child maltreatment
Already collected?	Yes
By?	The Illinois Department of Children and Family Services
MOU Needed?	Yes
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Reporting of suspected child maltreatment is subject to the opportunity to observe suspected maltreatment and the propensity to report it to the authorities.
Justification	Direct measure of the construct
Administered To:	N/A
Collection Schedule	Annually
Administered By:	Matching participants in the home visiting program to records of unsubstantiated reports of maltreatment in the Department of Children and Family Services' "SACWIS" database.
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Participating adults may not consent to release of their child's name and other identifying information for use in matching participant records to DCFS data.

Benchmark	Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
Construct	Reported substantiated maltreatment (substantiated/indicated/alternative response victim) for children in the program
Measure	Rate of maltreatment (allegations that were "indicated" [The Illinois Department of Children and Family Services' term for a substantiated report of abuse or neglect] among participating children.
Improvement is:	A decrease over time in the proportion of participating children who are maltreated.
Metric or Criterion:	The number of children participating in home visiting who were found to be maltreated during the reporting period, divided by the number of children participating in home visiting during the reporting period.
Data Collection	
Method	Matching participant data with data on indicated cases of child maltreatment
Already collected?	Yes
By?	The Illinois Department of Children and Family Services
MOU Needed?	Yes
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Reporting of child maltreatment is subject to the opportunity to observe suspected maltreatment and the propensity to report it to the authorities.
Justification	Direct measure of the construct
Administered To:	N/A
Collection Schedule	Annually
Administered By:	Matching participants in the home visiting program to records of indicated reports of maltreatment in the Department of Children and Family Services' Statewide Automated Child Welfare Information System (SACWIS) database.
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Participating adults may not consent to release of their child's name and other identifying information for use in matching participant records to DCFS data.

Benchmark	Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
Construct	First-time victims of maltreatment for children in the program
Measure	Rate of first reports of maltreatment (allegations that were "indicated" [The Illinois Department of Children and Family Services' term for a substantiated report of abuse or neglect] among participating children.
Improvement is:	A decrease over time in the proportion of participating children who are maltreated.
Metric or Criterion:	The number of children participating in home visiting who were found for the first time to have been maltreated during the reporting period, divided by the number of children participating in home visiting during the reporting period.
Data Collection	
Method	Matching participant data with child maltreatment data
Already collected?	Yes
By?	The Illinois Department of Children and Family Services
MOU Needed?	Yes
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Reporting of child maltreatment is subject to the opportunity to observe suspected maltreatment and the propensity to report it to the authorities.
Justification	Direct measure of the construct
Administered To:	N/A
Collection Schedule	Annually
Administered By:	Matching participants in the home visiting program to records of indicated reports of maltreatment in the Department of Children and Family Services' Statewide Automated Child Welfare Information System (SACWIS) database.
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Participating adults may not consent to release of their child's name and other identifying information for use in matching participant records to DCFS data.

Benchmark	Improvements in School Readiness and Achievement
Construct	Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child)
Measure	Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO)[41]
Improvement is:	An increase over time in parent support for children's learning and development
Metric or Criterion:	Number of parents active in the program who obtain a "normal" score on the PICCOLO for each observation during the reporting period, divided by the number of parents active in the program to whom the PICCOLO was administered for each observation during the reporting period.
Data Collection	
Method	Administration of a standardized instrument by an independent trained interviewer
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability/Validity	Authors report extensive field testing in numerous Head Start and Early Head Start programs. Scoring is based on over 2,000 parent-child interaction videos involving diverse populations (European-American, Latino-American and African American families). Authors report the tool is reliable, valid and practical to use for observing, tracking and supporting parenting interactions that lead to positive child development. Key constructs include affection, responsiveness, encouragement and teaching.
Limitations	Requires in-home observations of parent-child
Justification	Tool addresses many of the underlying constructs related to positive child development and the ability of parent to nurture and guide their child's learning
Administered To:	Parents
Collection Schedule	Collected at intake; 6-month; 12-month; annually; termination
Administered By:	Data collection contractor
Req'd Credentials	None cited by the developers
Req'd Training	Supporting material, including a DVD b ased training program are under development by Utah State University (Roggman and Innocenti)
Barriers / Challenges	Families may not consent to participating in data collection.

[41] Cook, G. A. & Roggman, L. (2009). *PICCOLO Technical Report*. Logan: Utah State University, Early Intervention Research Institute; Cook, G.A., Innocenti, M.S. & Roggman, L.A. (2010, February). *PICCOLO: An Easy to Use Observational Measure of Parent-Child Interactions to Guide Parenting Interventions and Track Program Outcomes*. Santa Barbara, CA: The Zigler Institute.

Benchmark	Improvements in School Readiness and Achievement
Construct	Parents' knowledge of child development and of their child's developmental progress.
Measure	Knowledge of Infant Development Inventory (KIDI)[42]
Improvement is:	An increase over time in parent's knowledge of child development and of their child's developmental progress
Metric or Criterion:	Number of parents active in the program who obtain a "normal" score on the KIDI for each observation during the reporting period, divided by the number of parents active in the program to whom the KIDI was administered for each observation during the reporting period.
Data Collection	
Method	Administration of a standardized instrument by a trained interviewer
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability/Validity	High internal consistency reported for parents (.82). Test-retest reliability for parents (2 week intervals) .92 for total score; .80 for accuracy; .80 for attempted. Repeated validity tests conducted by the author reports that persons with more experience with or knowledge about infants were more confident in responding to the KIDI and provided more accurate responses.
Limitations	None reported in the literature
Justification	This tool has been used by several parenting programs in Illinois for many years. It is relatively short and designed to be easily accessible to persons with limited education and to be culturally neutral.
Administered To:	Parents
Collection Schedule	Collected at intake; 6-month; 12-month; annually; termination
Administered By:	Data collection contractor
Req'd Credentials	None- Self-Administered
Req'd Training	None- Self-Administered
Barriers / Challenges	Families may not consent to participating in data collection.

[42]Knowledge of Infant Development Inventory (KIDI). MacPhee, D. (1981). *Manual: Knowledge of Infant Development Inventory*. Unpublished manuscript, University of North Carolina; MacPhee, D. (1983). *The Nature of Parents' Experiences with and Knowledge About Infant Development*. Paper presented at the Society for Research in Child Development; MacPhee, D. (1984). *The Relationship Between Children's Delayed Development and Their Mothers' Perceptions of Development.* Paper presented at the Southwestern Society for Research in Human Development; MacPhee, D. (1984) *Mothers' Acquisition and Reconstruction of Knowledge About Infancy*. Paper presented at the Southwestern Society for Research in Human Development.

Benchmark	Improvements in School Readiness and Achievement
Construct	Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)
Measure	Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO)[43]
Improvement is:	An improvement over time in parent-child interaction
Metric or Criterion:	Number of parents active in the program who obtain a "normal" score on the PICCOLO for each observation during the reporting period, divided by the number of parents active in the program to whom the PICCOLO was administered for each observation during the reporting period.
Data Collection	
Method	Administration of a standardized instrument by a trained interviewer
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability/Validity	Authors report extensive field testing in numerous Head Start and Early Head Start programs. Scoring is based on over 2,000 parent-child interaction videos involving diverse populations (European-American, Latino-American and African American families). Authors report the tool is reliable, valid and practical to use for observing, tracking and supporting parenting interactions that lead to positive child development. Key constructs include affection, responsiveness, encouragement and teaching.
Limitations	Requires in-home observations of parent-child
Justification	Tool addresses many of the underlying constructs related to positive child development and the ability of parent to nurture and guide their child's learning
Administered To:	Parents
Collection Schedule	Collected at intake; 6-month; 12-month; annually; termination
Administered By:	Data collection contractor
Req'd Credentials	None cited by the developers
Req'd Training	Supporting material, including a DVD b ased training program are under development by Utah State University (Roggman and Innocenti)
Barriers / Challenges	Families may not consent to participating in data collection.

[43] PICCOLO, Op. cit.

Benchmark	Improvements in School Readiness and Achievement
Construct	Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)
Measure	Conflict Tactics Scale for Parent and Child[44]
Improvement is:	An decrease over time in the proportion of parents who are using harsh disciplinary tactics
Metric or Criterion:	Number of parents who score in the "harsh measures" range at each on each administration of the CTS during the reporting period, divided by the number of parents to whom the CTS was administered for each observation during the reporting period.
Data Collection	
Method	Administration of a standardized instrument by a trained interviewer
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability/Validity	Measure has repeated shown moderate to high internal reliability on overall physical assault (.55); psychological aggression (.60); nonviolent discipline (.70); and neglect (.22). The authors tested for construct validity by examining the direction of the relationship between the subscale scores and demographic characteristics associated with child maltreatment such as age of parent, age of child, race/ethnicity and parent gender. The directions of the relationships were consistent with previous findings.[45]
Limitations	Questions may be of concern to respondents in that they address adverse parenting behaviors. Also the reported interactions may not be fully relevant until the child is at least 18 months of age.
Justification	The tool provides an alternative measure of assessing the child's risk for physical abuse.
Administered To:	Parents
Collection Schedule	Collected at intake; 6-month; 12-month; annually; termination
Administered By:	Data collection contractor
Req'd Credentials	None- Self-Administered
Req'd Training	None – Self-Administered
Barriers / Challenges	Families may not consent to participating in data collection.

[44] Conflict Tactics Scale for Parent and Child (CTSS). Straus, M.A., Hamby, S.L., Boney-McCoy, S., Sugarman, D. B. (1996). *The Revised Conflict Tactics Scale (CTS2): development and preliminary psychometric data*. Journal of Family Issues, 17: 283-316.

[45] Straud, M.A., Hamby, S.L., Finkelhor, D., Moore, D.W., & Runyan, D. (1998). Identification of child maltreatment with Parent-Child Conflict Tactics Scales: Development and psychometric Data for a national sample of American parents. Child Abuse and Neglect. 22(4).

Benchmark	Improvements in School Readiness and Achievement
Construct	Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)
Measure	Parenting Stress Index[46]
Improvement is:	A decrease over time in the level of parental stress
Metric or Criterion:	Number of parents obtaining a score in the "normal" range on the for each observation during the reporting period, divided by the number of parents to whom the Parenting Stress Index was administered for each observation during the reporting period.
Data Collection	
Method	Administration of a standardized instrument by a trained interviewer
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability/Validity	The reliability of the measure has been repeatedly produced reliability scores ranging from .55-.80 for various parent populations. Test-retest reliability after 1 year is .70. The measures validity is well established. Low scores correlate with parents having little investment in parenting or dysfunction in parent-child system. May also be found in parents with high defensiveness, supporting importance of administrator creating safe, accepting test environment.
Limitations	None reported in the literature
Justification	Commonly used measure of parental stress that has been normed for both English and Spanish speaking populations. Applicable for parents with children 1 to 12 years of age
Administered To:	Parents
Collection Schedule	Collected at intake; 6-month; 12-month; annually; termination
Administered By:	Data collection contractor
Req'd Credentials	None-Self-Administered
Req'd Training	None- Self-Administered
Barriers / Challenges	Families may not consent to participating in data collection.

[46] Parenting Stress Index, 3rd Edition (PSI). Abidin, R.R. (1995). Parenting Stress Index, Third Edition, Odessa, FL.: Psychological Assessment Resources.

Benchmark	Improvements in School Readiness and Achievement
Construct	Child's communication, language and emergent literacy
Measure	Ages and Stages Questionnaire, Third Edition (ASQ-3)[47]
Improvement is:	An increase over time in the proportion of children who are in the normal developmental range
Metric or Criterion:	The number of children who score in the "normal" range on the ASQ-3 at each observation in the reporting period, divided by the number of children to whom the ASQ-3 was administered at each observation during the reporting period.
Data Collection	
Method	Administration of a standardized instrument by a trained interviewer
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability/Validity	The measure has demonstrated high internal consistency across the various domains tested: communication (.63 to .75); gross motor (.53 to .87); fine motor (.49 to .79) problem solving (.52 to.75); and personal-social (.52 to .68). Test-retest between administrations was 94% and inter-rater reliability is 94%. General agreement in ratings has been found between the ASQ and other developmental measures ranging from 76 to 91%.
Limitations	None noted in the literature
Justification	ASQ is a commonly used assessment tool among home visiting programs as well as others serving young children. Compared to other child development assessment tools it is relatively easy to administer and score. This metric is consistent with the national Medicaid HEDIS measure for Objective Developmental Screening
Administered To:	Parents
Collection Schedule	Collected at 6-months; 12-month; annually
Administered By:	Data collection contractor
Req'd Credentials	Professionals or trained paraprofessionals
Req'd Training	User guide contains complete instructions for each of the phases of the questionnaire. Other support material includes guidelines for choosing referral criteria, activities sheets that correspond to the ASQ age intervals. Training is also provided by the Michigan Public Health Institute. A videotape is available that provides guidance on using the ASQ in a home visiting context.
Barriers / Challenges	Families may not consent to participating in data collection.

[47] Ages & Stages Third Edition (ASQ-3). Squires, J. & Bricker, D. (2009). Ages & Stages Questionnaires, Third Edition: A Parent-Completed Child-Monitoring System. Baltimore, MD.: Brooks Publishing.

Benchmark	Improvements in School Readiness and Achievement
Construct	Child's general cognitive skills
Measure	Ages and Stages Questionnaire, Third Edition (ASQ-3)[48]
Improvement is:	An increase over time in the proportion of children who are in the normal range for general cognitive skills.
Metric or Criterion:	The number of children who score in the "normal" range on the ASQ-3 at each observation in the reporting period, divided by the number of children to whom the ASQ-3 was administered at each observation during the reporting period.
Data Collection	
Method	Administration of a standardized instrument by a trained interviewer
Already collected?	No
By?	N/A
MOU Needed?	No.
Reliability/Validity	The measure has demonstrated high internal consistency across the various domains tested: communication (.63 to .75); gross motor (.53 to .87); fine motor (.49 to .79) problem solving (.52 to.75); and personal-social (.52 to .68). Test-retest between administrations was 94% and inter-rater reliability is 94%. General agreement in ratings has been found between the ASQ and other developmental measures ranging from 76 to 91%.
Limitations	None noted in the literature
Justification	ASQ is a commonly used assessment tool among home visiting programs as well as others serving young children. Compared to other child development assessment tools it is relatively easy to administer and score. This measure is consistent with the national Medicaid HEDIS measure for Objective Developmental Screening.
Administered To:	Parents
Collection Schedule	Collected at 6-month; 12-month; annually
Administered By:	Self-administered
Req'd Credentials	Professionals or trained paraprofessionals
Req'd Training	User guide contains complete instructions for each of the phases of the questionnaire. Other support material includes guidelines for choosing referral criteria, activities sheets that correspond to the ASQ age intervals. Training is also provided by the Michigan Public Health Institute. A videotape is available that provides guidance on using the ASQ in a home visiting context.
Barriers / Challenges	Families may not consent to data collection

[48] Ages & Stages Third Edition (ASQ-3). Ibid.

Benchmark	Improvements in School Readiness and Achievement
Construct	Child's positive approaches to learning including attention
Measure	Ages and Stages Questionnaire: Social Emotional scales
Improvement is:	An increase over time in the proportion of children who are in the "normal" range for positive approaches to learning.
Metric or Criterion:	The number of children who are in the "normal" range on the ASQ:SE for each observation in the reporting period, divided by the number of children to whom the ASQ:SE was administered for each observation in the reporting period.
Data Collection	
Method	Administration of a standardized instrument by a trained interviewer
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability/Validity	Internal consistency, 67%-91%, Chronbach's α; test-retest reliability, 94%; concurrent validity, 93% overall; sensitivity, 87% overall; specificity, 95% overall[49]
Limitations	None noted.
Justification	The tool is strength based that assesses the presence of protective factors as well as screens for social and emotional risks in very young children.
Administered To:	Parents
Collection Schedule	Collected at 1-month, 6 months and 12-months
Administered By:	Data collection contractor
Req'd Credentials	None
Req'd Training	Directions provided in the ASQ:SE User's Guide
Barriers / Challenges	Families may not consent to participating in data collection.

[49] Brookes Publishing Company. Technical Report on ASQ;SE. http://agesandstages.com/pdfs/asqse_technical_report.pdf

Benchmark	Improvements in School Readiness and Achievement
Construct	Child's social behavior, emotional regulation and emotional well-being
Measure	Ages and Stages Questionnaire: Social Emotional scales (ASQ:SE)
Improvement is:	An increase over time in the proportion of children who are in the "normal" range for social behavior, emotional regulation and emotional well-being.
Metric or Criterion:	The number of children who are in the "normal" range on the ASQ:SE for each observation in the reporting period, divided by the number of children to whom the ASQ:SE was administered for each observation in the reporting period.
Data Collection	
Method	Administration of a standardized instrument by a trained interviewer
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability/Validity	Internal consistency, 67%-91%, Chronbach's α; test-retest reliability, 94%; concurrent validity, 93% overall; sensitivity, 87% overall; specificity, 95% overall[50]
Limitations	None noted.
Justification	The tool is strength based that assesses the presence of protective factors as well as screens for social and emotional risks in very young children.
Administered To:	Parents
Collection Schedule	Collected at 1-month, 6 months and 12-months
Administered By:	Data collection contractor
Req'd Credentials	None
Req'd Training	Directions provided in the ASQ:SE User's Guide
Barriers / Challenges	Families may not consent to participating in data collection.

[50] Brookes Publishing Company. Technical Report on ASQ;SE. http://agesandstages.com/pdfs/asqse_technical_report.pdf

Benchmark	Improvements in School Readiness and Achievement
Construct	Child's physical health and development
Measure	Height (or length) and weight
Improvement is:	An increase over time in the proportion of children between the 10th and 85th percentile on height and weight.
Metric or Criterion:	The number of children between the 10th and 85th percentile for height and weight at each observation in the reporting period, divided by the number of children from whom height (length) and weight were collected for each observation during the reporting period.
Data Collection	
Method	Matching participant records to measurement of head circumference, height and weight by a WIC program staff in the Cornerstone MIS.
Already collected?	Yes
By?	IDHS WIC program grantees
MOU Needed?	No
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	Limited to children participating in the WIC program. A high rate of participation is expected.
Justification	Direct measure of the construct
Administered To:	Collected from children participating in the WIC program.
Collection Schedule	At WIC enrollment and every six months thereafter.
Administered By:	Collected by WIC program staff
Req'd Credentials	WIC certifying health professional
Req'd Training	WIC certifying health professional
Barriers / Challenges	Families may not consent to participating in data collection.

Benchmark	Domestic Violence
Construct	Screening for domestic violence
Measure	A brief screening instrument recommended by the IDHS Bureau of Domestic and Sexual Violence Prevention and the Illinois Coalition Against Domestic Violence will be used.
Improvement is:	An increase over time in the number of women who are screened for domestic violence
Metric or Criterion:	The number of women participating in home visiting during the reporting period who were screened for domestic violence, divided by the number of women participating in home visiting during the reporting period.
Data Collection	
Method	Reported by the home visitor
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A – administrative data
Validity	N/ A – administrative data
Limitations	N/A
Justification	Direct measure of the construct.
Administered To:	Mothers, unless the home visitor suspects that the mother is perpetrating the abuse.
Collection Schedule	At least once during pregnancy or the first two months postpartum
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	Completion of 40 hours of domestic violence in-service training
Barriers / Challenges	Families may not consent to participating in data collection.

Benchmark	Domestic Violence
Construct	Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services
Measure	Proportion of women experiencing domestic violence who are referred to relevant domestic violence services.
Improvement is:	An increase over time in the proportion of women experiencing domestic violence who are referred to appropriate domestic violence services
Metric or Criterion:	The number of women identified as experiencing domestic violence during the reporting period who are referred for relevant domestic violence services, divided by the number of women who were identified as experiencing domestic violence during the reporting period.
Data Collection	
Method	Referral reported by the home visitor
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	N/A – documentation found in case records
Justification	Direct measure of the construct.
Administered To:	Mothers, unless the home visitor suspects that the mother is perpetrating the abuse.
Collection Schedule	Immediately following a positive screening result for domestic violence
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	Completion of 40 hours of domestic violence in-service training
Barriers / Challenges	Families may not consent to participating in data collection.

Benchmark	Domestic Violence
Construct	Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.
Measure	Proportion of women referred to relevant domestic violence services who develop a safety plan.
Improvement is:	An increase over time in the proportion of women referred to appropriate domestic violence services who develop a safety plan
Metric or Criterion:	The number of women referred for relevant domestic violence services who develop a safety plan during the reporting period, divided by the number of women who were referred for relevant domestic violence services during the reporting period.
Data Collection	
Method	Mother's self report of having completed a safety plan
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A
Validity	N/A
Limitations	The measure will be inaccurate when women are referred in one reporting period and develop a safety plan in a subsequent reporting period.
Justification	Direct measure of the construct.
Administered To:	Self-report from mothers, unless the home visitor suspects that the mother is perpetrating the abuse (in which case, data are collected from her partner.
Collection Schedule	After completion of a referral for relevant domestic violence services.
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	Completion of 40 hours of domestic violence in-service training
Barriers / Challenges	Families may not consent to participating in data collection.

Benchmark	Family Economic Self-Sufficiency
Construct	Household[51] income and benefits[52]
Measure	The proportion of families who report an increase in household income and benefits after one year of program participation
Improvement is:	An increase over time in total household income and benefits.
Metric or Criterion:	The number of families whose total household income and benefits one year after enrollment is greater than it was at the time of enrollment, divided the number of families who have participated in the program for one year.
Data Collection	
Method	Parental self-report
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	Self-reported
Validity	Self-reported
Limitations	Self-reported income and benefits
Justification	Direct measure of the construct
Administered To:	Families
Collection Schedule	During the month of enrollment and one year after enrollment
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Families may be unwilling to disclose total income and benefits.

[51] "Household" is defined as all those living in a home (who stay there at least four nights a week on average) who contribute to the support of the child or pregnant woman linked to the home visiting program. (Tenants and borders are not counted as members of the household.)

[52] "Income and benefits" are defined as earnings from work, plus other sources of cash suppot. These sources may be private, i.e., rent from tenants or boarders, cash assistance from friends or relatives, or they may e linked to public c systems, i.e. child support payments, TANF, Social Security (SSI/SSDI/OAI), and Unemployment Insurance.

Benchmark	Family Economic Self-Sufficiency
Construct	Employment or Education of adult members of the household
Measure	The number of adults in participating households who are employed
Improvement is:	An increase in the number of employed adults in participating households over time.
Metric or Criterion:	The number of families participating in the program who report an increase in the number of adult household members who are employed after one year of program participation, divided by the number of families who have completed one year of participation in the program.
Data Collection	
Method	Parental self-report
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A – self-reported
Validity	N/A – self-reported
Limitations	Self-reported information
Justification	Direct measure of the construct
Administered To:	Collected from participating families
Collection Schedule	During the month of enrollment and one year after enrollment;
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Families may not consent to participate in data collection

Benchmark	Family Economic Self-Sufficiency
Construct	Employment or Education of adult members of the household
Measure	The average number of paid hours worked and the number of hours devoted to the care of an infant in a month by adults in participating households
Improvement is:	An increase in the average number of paid hours worked and the number of hours devoted to the care of an infant by all adults in participating households over time.
Metric or Criterion:	The number of families participating in the program who report an increase during the first year of program participation in the average number of hours worked and the number of hours devoted to care of an infant during a month, divided by the number of families who have completed one year of enrollment in the program.
Data Collection	
Method	Parental self-report
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A – self-reported
Validity	N/A – self-reported
Limitations	Self-reported information
Justification	Direct measure of the construct
Administered To:	Collected from participating families
Collection Schedule	During the month of enrollment and one year after enrollment;
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Families may not consent to participate in data collection

Benchmark	Family Economic Self-Sufficiency
Construct	Employment or Education of adult members of the household
Measure	The number adult household members who have graduated from high school or obtained a General Equivalency Diploma
Improvement is:	An increase over time in the proportion of families who have completed high school or obtained a General Equivalency Diploma
Metric or Criterion:	The number of families participating in the program who have graduated from high school or obtained a General Equivalency Diploma by the end of the reporting period, divided by the number of families participating in the program at the end of the reporting period.
Data Collection	
Method	Parental self-report
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A – self-reported
Validity	N/A – self-reported
Limitations	Self-reported information
Justification	Direct measure of the construct
Administered To:	Collected from participating families
Collection Schedule	Annually
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Families may not consent to participate in data collection

Benchmark	Family Economic Self-Sufficiency
Construct	Employment or Education of adult members of the household
Measure	The number adult household members who have completed a post-secondary education or training program.
Improvement is:	An increase over time in the proportion of families who have completed a post-secondary education or training program
Metric or Criterion:	The number of families participating in the program who have completed a post-secondary education or training program by the end of the reporting period, divided by the number of families participating in the program at the end of the reporting period.
Data Collection	
Method	Parental self-report
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A – self-reported
Validity	N/A – self-reported
Limitations	Self-reported information
Justification	Direct measure of the construct
Administered To:	Collected from participating families
Collection Schedule	Annually
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Families may not consent to participate in data collection

Benchmark	Family Economic Self-Sufficiency
Construct	Employment or Education of adult members of the household
Measure	The number of adult household members participating in educational activities.
Improvement is:	An increase over time in the proportion of adult household members who have participated in educational activities during the first year of program enrollment
Metric or Criterion:	The number of adult members of households participating in the program who have participated in educational activities during the first year of program participation, divided by the number of households who have completed one year of program participation..
Data Collection	
Method	Parental Self-Report
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A – self-reported
Validity	N/A – self-reported
Limitations	Self-reported information
Justification	Direct measure of the construct
Administered To:	Collected from participating families
Collection Schedule	During the first month of enrollment and during the month one year after enrollment.
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Families may not consent to participate in data collection

Benchmark	Family Economic Self-Sufficiency
Construct	Employment or Education of adult members of the household
Measure	The average number of hours per month spent by each adult household member in educational programs
Improvement is:	An increase over time in the average number of hours that adult household members spend per month in educational activities during the first year of program enrollment
Metric or Criterion:	The number of families participating in the program who report an increase in the average number of hours that adult members of the household have participated in educational activities during the first year of program participation, divided by the number of households who have completed one year of program participation..
Data Collection	
Method	Parental Self-Report
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A – self-reported
Validity	N/A – self-reported
Limitations	Self-reported information
Justification	Direct measure of the construct
Administered To:	Collected from participating families
Collection Schedule	During the first month of enrollment and during the month one year after enrollment.
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Families may not consent to participate in data collection

Benchmark	Family Economic Self-Sufficiency
Construct	Employment or Education of adult members of the household
Measure	The average number of hours per month spent by each adult household member in employment, educational programs and care of an infant
Improvement is:	An increase over time in the average number of hours that adult household members spend per month in employment, educational activities and care of an infant during the first year of program enrollment
Metric or Criterion:	The number of families participating in the program who report an increase in the average number of hours that adult members of the household have spent in employment, participating in educational activities and providing care for an infant during the first year of program participation, divided by the number of households who have completed one year of program participation..
Data Collection	
Method	Parental Self-Report
Already collected?	No
By?	N/A
MOU Needed?	No
Reliability	N/A – self-reported
Validity	N/A – self-reported
Limitations	Self-reported information
Justification	Direct measure of the construct. This combined measure offsets the inverse relationships among hours spent in employment, child care and educational activities.
Administered To:	Collected from participating families
Collection Schedule	During the first month of enrollment and during the month one year after enrollment.
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Families may not consent to participate in data collection.

Benchmark	Family Economic Self-Sufficiency
Construct	Health insurance status
Measure	The number of participating families who have health insurance coverage for all household members
Improvement is:	An increase over time in the number of household members who have health insurance.
Metric or Criterion:	The number of families with all family members covered by public or private health insurance at the end of the reporting period, divided by the number of active families at the end of the reporting period.
Data Collection	
Method	Parental self-report and IDHS enrollment data
Already collected?	Yes
By?	Illinois Department of Human Services
MOU Needed?	No
Reliability	N/A – self-reported
Validity	N/A – self-reported
Limitations	Self-reported information, taken at one point in time each year, will only reflect coverage at one point in time.
Justification	Direct measure of the construct
Administered To:	Collected from participating families
Collection Schedule	Annually
Administered By:	Home visitor
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	Community unemployment rates will adversely affect family health insurance coverage

Benchmark	Coordination and Referrals for Other Community Resources and Supports
Construct	Number of families identified for necessary services
Measure	The number of families assessed for service needs
Improvement is:	An increase over time in the proportion of families assessed for service needs, particularly those relevant for affecting participant outcomes
Metric or Criterion:	The number of participating families who have been assessed for service needs during the reporting period, divided by the number of families participating during the reporting period.
Data Collection	
Method	Report by the home visitor
Already collected?	No.
By?	N/A
MOU Needed?	No.
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	N/A – administrative data
Justification	Direct measure of the construct
Administered To:	Collected from home visitors
Collection Schedule	Quarterly
Administered By:	Reported by the home visitor
Req'd Credentials	None
Req'd Training	Case management training
Barriers / Challenges	None.

Benchmark	Coordination and Referrals for Other Community Resources and Supports
Construct	Number of families that required services and received a referral to available community resources
Measure	The number of families referred to available community resources to address service needs
Improvement is:	An increase over time in the proportion of families with identified service needs who are referred to available community resources
Metric or Criterion:	The number of participating families with an identified service need who are referred to an available community service during the reporting period, divided by the number of families identified as having a service need during the reporting period.
Data Collection	
Method	Report by the home visitor
Already collected?	No.
By?	N/A
MOU Needed?	No.
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	N/A – administrative data
Justification	Direct measure of the construct
Administered To:	Collected from home visitors
Collection Schedule	Quarterly
Administered By:	Reported by the home visitor
Req'd Credentials	None
Req'd Training	Case management training
Barriers / Challenges	None.

Benchmark	Coordination and Referrals for Other Community Resources and Supports
Construct	Number of completed referrals
Measure	The number of families who complete referrals to available community resources
Improvement is:	An increase over time in the proportion of families referred for services who complete the referral
Metric or Criterion:	The number of participating families referred to an available community who complete the service referral during the reporting period, divided by the number of families referred for services during the reporting period.
Data Collection	
Method	Report by the home visitor
Already collected?	No.
By?	N/A
MOU Needed?	No.
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	N/A – administrative data
Justification	Direct measure of the construct
Administered To:	Collected from home visitors
Collection Schedule	Quarterly
Administered By:	Reported by the home visitor
Req'd Credentials	None
Req'd Training	Case management training
Barriers / Challenges	None.

Benchmark	Coordination and Referrals for Other Community Resources and Supports
Construct	Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies
Measure	The number of community agencies with which the home visiting provider has an identified contact person.
Improvement is:	An increase over time in the number of community agencies with which the home visiting provider has an identified contact person
Metric or Criterion:	The number of agencies in the community which serve families with young children with which the home visiting provider has an identified contact person.
Data Collection	
Method	Report by the home visiting agency
Already collected?	No.
By?	
MOU Needed?	No.
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	N/A – administrative data
Justification	Direct measure of the construct
Administered To:	Collected from home visitors
Collection Schedule	Quarterly
Administered By:	Reported by the home visiting agency
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	None

Benchmark	Coordination and Referrals for Other Community Resources and Supports
Construct	Number of agencies with which the home visiting provider has established a formal Memorandum of Understanding for the coordination of services and exchange of information.
Measure	The number of community agencies with which the home visiting provider has established a formal Memorandum of Understanding
Improvement is:	An increase over time in the number of community agencies with which the home visiting provider has established formal memoranda of understanding for the coordination of services and exchange of information.
Metric or Criterion:	The number of agencies in the community which serve families with young children with which the home visiting provider has established a formal memorandum of understanding.
Data Collection	
Method	Report by the home visiting agency
Already collected?	No.
By?	N/A
MOU Needed?	No.
Reliability	N/A – administrative data
Validity	N/A – administrative data
Limitations	N/A – administrative data
Justification	Direct measure of the construct
Administered To:	Collected from home visitors
Collection Schedule	Quarterly
Administered By:	Reported by the home visiting agency
Req'd Credentials	None
Req'd Training	None
Barriers / Challenges	None

Section 6: Plan for Administration of the State Home Visiting Program

Illinois' overall approach to the administration of MIECHVP can be summarized as follows. Policy leadership on the development of a statewide system of home visiting programs is provided by the Governor's Office of Early Childhood Development, the Early Learning Council and the Council's Home Visiting Task Force. Grants to support local home visiting programs will be overseen by the state funding agencies; at this stage of implementation, grants of MIECHVP funds will be overseen by the Bureau of Child and Adolescent Health in the Illinois Department of Human Services' Division of Community Health and Prevention.

This management plan meets statutory requirements. State and local program staff will be recruited and selected in accordance with established personnel policies. Training of the new MIECHVP program staff at the local level will be provided through the Illinois Birth To Three Institute, which has been training local program staff for nearly three decades.. Program managers and supervisors will receive training on high-quality, reflective supervision. NFP' NSO will provide the education, training, ongoing education, and clinical support for NFP administrators, supervisors, and staff-NFP staff utilize the IBTI trainings as supplemental or wrap-around trainings as they support the NFP home visit guidelines. State staff will work closely with the model developers to ensure that local programs are designed, implemented and managed with fidelity. Home visiting programs will be integrated into community referral networks and monitoring operations to ensure fidelity with national standards. Illinois' plan for MIECHVP is consistent with the plans of the State Advisory Council on Early Care and Education and the State Early Childhood Comprehensive Systems initiative. This new federal initiative will be integrated with related state and federal initiatives to improve early childhood development.

Lead Agency and Overall Management Plan. The MIECHVP Project Director will report to the Director of the Governor's Office of Early Childhood Development. This reporting relationship has been established to support coordination of activities among the Illinois Department of Human Services, the Illinois State Board of Education, the Illinois Department of Children and Family Services, the Illinois Department of Healthcare and Family Services, and the Illinois Department of Public Health. The Project Director for MIECHVP will also serve as the Project Director for the "Supporting Evidence-Based Home Visiting Programs to Prevent Child Maltreatment" grant from the federal Administration for Children and Families.

The Illinois Department of Human Services will be the lead agency for implementation of the MIECHVP in Illinois. Responsibility for administration of grant funds and for monitoring local home visiting program implementation rests with the Bureau of Child and Adolescent Health of the Illinois Department of Human Services' Division of Community Health and Prevention. This bureau is also responsible for management of the Healthy Families Illinois and Parents Too Soon programs. The Associate Director for Reproductive and Early Childhood Services (Illinois' Title V Director) will serve as the primary contact with the federal Maternal and Child Health Bureau and ensure coordination of MIECHVP activities with other programs and services supported by the Maternal and Child Health Services Block Grant.

This administrative structure ensures that the management of program grant funds is closely coordinated with the other home visiting programs that are part of Illinois' Maternal and Child Health program; ensures that MIECHVP is closely coordinated with the rest of Title V; ensures that the home visiting programs operated by IDHS will be coordinated with those operated by ISBE; and ensures that the home visiting programs will be coordinated with the publicly-funded ancillary services that many participating families will require.

Collaborative Partners in the Public and Private Sectors. The membership of Illinois' Home Visiting Task Force was presented in Section 4. The local agencies from each community that participated in the selection of models for their communities were presented in Section 1.

Plan for Coordination Among Home Visiting Programs. Illinois' plan for universal screening and coordinated intake was presented in Section 4 (see, "Identification and Recruitment of Participants").

Current Evaluations. No evaluations of local home visiting programs are currently underway.

Job descriptions and resumés. Please refer to Appendix 3 for descriptions of the roles of Project Director, Evaluation Coordinator, Fiscal Manager and Data Manager. The Project Director's resumé is in that Appendix as well.

Organization Chart. Please refer to Appendix 4 for a copy of the MIECHVP Organization Chart.

Meeting The Requirements of Title V, Section 511

Well-trained, Competent Staff. State staff will be hired according to the policies and procedures established by the Illinois Personnel Code (20 ILCS 415 et seq.). According to the Illinois Department of Central Management Services (IDCMS), which is responsible for the administration of the code, it:

> "… is the law that provides the basis for the civil service merit system in Illinois. It embraces all positions of employment in the service of the state unless specifically excluded by legislation. It empowers the Director of Central Management Services to promulgate Rules and carry out this law, and creates the Civil Service Commission to monitor its proper administration and to conduct hearings.
>
> "The Code consists of three jurisdictions: Jurisdiction A, Classification & Pay, which provides for a system of pay administration and position reporting and classification to assure that the work of employees is fairly compensated, consistent with the level and kind of job they perform; Jurisdiction B, Merit & Fitness, covering candidate testing and selection, certification, performance appraisal and discipline, and other merit practices for employees; Jurisdiction C, Conditions of Employment, which deals with such things as vacation, holidays,

> sick time, grievance plans, and other provisions that establish a body of uniform personnel practices across agencies.
>
> "…The Personnel Code was written to provide broad administrative powers to the Director, to carry out a personnel program "based upon merit principles and scientific methods", and indeed the law survived with little change over the years, and has been able to embrace a number of significant changes in the human resources field without the need for a major overhaul." (IDCMS)

Positions that are subject to a collective bargaining agreement will be governed by the State of Illinois' current agreement with the American Federation of State, County and Municipal Employees (AFSCME).

Positions are established by the IDCMS using a job description prepared by the employing agency. The description is used to classify the position and assign a payroll title. This determines the position's annual salary and determines whether the position is subject to a collective bargaining agreement.

The position descriptions submitted with the original proposal for MIECHVP and this Implementation Plan were prepared from specifications developed and approved by IDCMS and serve as the basis for establishing and classifying these positions. Each job description specified the education and work experience required to successfully carry out the position's responsibilities. The Project Director's position is classified as a Senior Public Service Administrator and so is exempt from the U.S. Supreme Court's *Rutan* decision[53] (which forbids the consideration of political affiliation in personnel decisions). The Evaluation Coordinator is classified as a Public Service Administrator Option 6 and the Fiscal Manager is classified as a Public Service Administrator Option 2. Both of these positions are subject to the State of Illinois' collective bargaining agreement with AFSCME.

Local staff. Recruitment, selection, hiring, compensation and other personnel actions are the responsibility of the community-based organizations that will be selected to implement the home visiting programs. Local agencies will be required to provide job descriptions and, when possible, resumés, for positions in their home visiting programs and the management staff who will be responsible for administration of the program. These documents will be reviewed by IDHS staff and the other members of the Strong Foundations Partnership selection committee to ensure that they meet the requirements established by the developer of the model (or developers of the models) that the community has chosen to implement. Agencies implementing NFP will collaborate with NSO personnel, as required by the proprietary implementation agreement.

High Quality Supervision. The Executive Committee's understanding of and commitment to reflective supervision was presented in Section 4, under "Clinical Supervision and Reflective Practice."

Capacity of Local Organizations. IDHS' RFP will ask local organizations to describe their current and prior experience in serving families with young children in general and home visiting

[53] Rutan v. Republican Party of Illinois, 497 U.S. 62 (1990)

in particular. Organizations with extensive experience are given more weight with regard to that aspect of their proposals.

Referral and service Networks. Please refer to "Coordination of Ancillary Services" in Section 4 for the state's plan to ensure that families in home visiting programs will be able to access the additional services that they require.

Monitoring of fidelity. Please refer to "Ensuring Implementation with Fidelity" in Section 3 for the state's plan to monitor fidelity to the national model.

Coordination with the State Advisory Council on Early Education and Care. Illinois' proposal for funds to support the State Advisory Council on Early Education and Care, as authorized by 642B(b)(1)(A)(i) of the Head Start Act, identified six goals. The plan is being implemented by the Governor's Office of Early Childhood Development (OECD) and the Early Learning Council ("the Council"). The MIECHVP directly pertains to goals 1, 3, 4 and 5. The six goals are:

1: Engage Vulnerable Children and Families in High-Quality Early Childhood Education

To achieve this goal, the Council and the OECD are testing strategies to engage "hard-to-reach" children and families in early care and education. The goal of this demonstration project is to increase the participation of high-need, hard-to-reach populations of children in all Illinois state- and federally-funded quality early care and education programs. MIECHVP will contribute to this effort through the development and testing of a community system for universal screening.

2: Increase Early Childhood Facilities in Underserved Communities

To achieve this objective, the OECD and the Council are providing organizations and municipalities with technical assistance on capital projects to help them successfully apply for state funding for the building and renovation of early childhood education and care centers in underserved communities.

3: Increase Community Collaborations and Partnerships

To achieve this goal, the OECD and the Council's Community Systems Development Work Group is supporting local community partnerships in serving young children and their families by raising awareness about the importance of community collaboration and partnerships as well as providing local technical assistance to build strong systems and partnerships in Illinois communities. The Work Group will achieve this priority objective through the following three goals in the coming three years: (1) develop and maintain a technical assistance support system to establish new and strengthen existing local community collaborations and systems; (2) establish designated public funds to support local community collaboration efforts; and (3) build on the network of community level collaborative systems across Illinois. The efforts of the Council and the MIECHVP to develop integrated early childhood service delivery systems in the target communities will complement one another to achieve this goal.

4: Early Childhood Data System

To support these efforts, the OECD and the Council will develop and begin to implement a plan to create a unified early childhood data system that integrates current systems and provides new data on Illinois' birth-to-five programs. The three-year goal is to design an early childhood data system that would enable:

- Data collection on children from birth to age five who are receiving state- or federally-funded early childhood services;
- Data collection on programs serving children, ages birth to five, that receive state or federal funds, including data on practitioners working in these programs;
- Varying levels of user access to system information; and
- The integration of current data systems (e.g. early childhood care and education, health, child welfare, etc.).

The Council's data work group has focused on the development of an information system that will support state- and federally-funded early care and education programs, with a long-term goal of encompassing all early childhood services. The initial and final information systems for MIECHVP will include comparable information on participants in home visiting programs.

5: Birth-to-Three Monitoring System

To address this priority, the OECD and the Council will support state-funded home visiting programs in completing their respective national program model's credentialing process. The programs supported by MIECHVP will be required to complete the certification process prescribed by the model developer. The work of the Council and of the MIECHVP will complement one another and contribute to the achievement of this priority.

6: Strengthen Illinois' Professional Development System

The OECD and the Council will strengthen Illinois' professional development system in two important ways: increasing opportunities for early childhood practitioners to obtain their credentials, and implementing two Intensive Faculty Institutes to better prepare teachers to meet the needs of all Illinois children. By addressing these key barriers, the Council will further Illinois' professional development system to prepare a well-qualified workforce. The specific, three-year goals of this priority objective are to: (1) provide additional funding to the Illinois Gateways to Opportunity Scholarship Program[54] to increase opportunities for practitioners who are working to increase their expertise in early childhood education; and (2) provide Intensive Faculty Institutes for early childhood and bilingual higher education faculty members to develop strategies for effectively preparing the early childhood workforce. This goal is primarily focused on early care and education.

State Early Childhood Comprehensive Systems (SECCS) Initiative Strategic Plan. The implementation of MIECHVP is the first objective in Illinois' SECCS Strategic Plan. MIECHVP will also contribute to the achievement of several other objectives in the SECCS plan, including:

[54] http://www.ilgateways.com/

- Activities 3 and 4 under Objective 1.2 ("Develop and implement a system of referral and coordination to ensure children who may be at-risk for a developmental delay or disability receive appropriate referral to preventive child development services and programs") through the linkages that will be established between home visiting programs and providers of ancillary services;
- Objective 1.3 ("Support the development and implementation of systems to build and sustain local community partnerships") through the early childhood service networks that will be established in the target communities;
- Objective 1.4 ("Advance recommendations for the development of an enhanced and coordinated monitoring system for government-funded Infant-Toddler programs") by requiring that local programs maintain certification by model developers and by collection of data on program fidelity;
- Objective 1.6 ("Ensure early childhood programs and staff meet the needs of culturally and linguistically diverse young children") through staffing, training and appropriate adaptation of curricula; and
- Objective 1.8 ("Develop a strategy regarding implementation of school readiness assessments in Illinois") through the collection of data for Benchmark #4 ("Improvements in school readiness and child academic achievement").

Compliance with Model-Specific Prerequisites. IDHS and the other members of the Executive Committee will work closely with the model developers to ensure that prerequisites for each model are met. IDHS has been implementing and monitoring Healthy Families Illinois programs for 14 years. Four models – PAT, NFP, Healthy Steps and Early Head Start – require local organizations to prepare and submit a program plan for review and approval by the model developer. IDHS will use these guidelines to ensure that the materials required by the model developers are included in the RFP that will be issued to select an implementation agency. The proposal submitted by each community will also be forwarded to the appropriate state or national office to initiate this process. In this way, IDHS will ensure that proposed programs are designed to meet national standards before funds are awarded.

Changes to State Administrative Structure. Illinois' administrative structure for MIECHVP was described in Section 1 and at the beginning of this section. No changes to the administrative structure have been made since the original application was submitted in July 2010. Illinois' Acting Title V Director and other IDHS staff worked closely with Region V staff from the Maternal and Child Health Bureau to clarify the administrative structure. These discussions culminated in the Organization Chart that is included in the Appendices of this Implementation Plan.

Collaborations Established with Other Early Childhood Initiatives. The Division of Community Health and Prevention at IDHS is responsible for the administration of several special early childhood initiatives, as well as on-going programs that serve families with young children.

Two of the communities in the cluster on the south side are served by the Greater Englewood Healthy Start Initiative and the third community in that cluster is served by IDHS' Chicago Healthy Start Initiative. Two of the communities (Elgin and Macon County) are served by one

of IDHS' All Our Kids Early Childhood Networks. Two of the Target Areas are also served by one of DCHP's Targeted Intensive Prenatal Case Management programs. This initiative targets communities with elevated rates of low birth weight and uses a variety of strategies to engage at-risk women early in pregnancy and ensure that they have access to prenatal care and other health and human services.

All of the Target Areas are served by IDHS' state-wide programs for families with young children, including WIC (the Special Supplemental Nutrition Program for Women, Infants and Children); Early Intervention (Part C of the Individuals with Disabilities Education Act), Family Case Management (a state-funded program to reduce infant mortality), Family Planning (which is supported with federal Title X funds) and Teen Parent Services (which assists low-income teen parents with parenting, education and employment).

Children who are eligible to participate in Illinois' All Kids program also participate in Health Connect, a statewide Primary Care Case Management (PCCM) program for most persons covered by All Kids or FamilyCare.[55] Participants are assigned to a medical home through a Primary Care Provider (PCP), which ensures that clients have access to quality care from a provider who understands their individual health care needs. A client's PCP serves as his/her medical home by providing, coordinating and managing the client's primary and preventive services, including well child visits, immunizations, screening, and follow-up care as needed. Having a PCP also helps those with chronic conditions like asthma, heart disease or diabetes to get the treatment and ongoing care they need to minimize the need for hospital care. The PCP will also make referrals to specialists for additional care or tests as needed. There are currently over 1.9 million Illinois Health Connect clients with a PCP in a medical home. Information about the program is provided at www.illinoishealthconnect.com.

Section 7: Plan for Continuous Quality Improvement

Illinois' plan for MIECHVP includes a strong commitment to Continuous Quality Improvement (CQI). The Division of Community Health and Prevention already has extensive experience with this approach. More than a decade ago, Division staff launched a CQI effort to integrate the delivery of two state-wide programs for families with young children: the state-funded Family Case Management program, which was launched in the late 1980's to reduce Illinois' infant mortality rate, and the federally-funded Special Supplemental Nutrition Program for Women, Infants and Children. The effort to integrate the delivery of these programs was launched when program data demonstrated a significant improvement in infant mortality, low birth weight and very low birth weight rates when families participated in both programs. In addition to extensive technical assistance to local agencies, data in the form of a color-coded state map was distributed quarterly to all service providers. The maps shaded each county red, yellow or green depending on the degree of integration (cross-enrollment) between the two programs. The campaign continued for about two years until full integration had been achieved in almost all of the state, and new strategies were formulated to achieve additional progress. A similar approach was used to increase the rate of childhood immunization among WIC participants.

[55] This IDHFS program provides coverage for parents and relatives who care for children under age 19.

This section of the MIECHVP implementation plan will discuss the values underlying this approach to CQI, as well as the proposed structure, process and topics that may be considered through this effort. Topics for CQI of home visiting, universal screening and coordinated intake and the early childhood network are presented.

Values Supporting CQI. Two sets of values underlie the Executive Committee's approach to continuous quality improvement in the application of CQI to home visiting.

The first set of values includes the assumptions that we make about the intentions of distressed families and why they participate in home visiting. We assume that new and expectant parents want to do the best job of parenting that they can. We assume that all families need both concrete and social supports in order to succeed as parents. Finally, we assume that distressed families – due to young age, social (as well as linguistic and cultural) isolation, depression, substance abuse, violence, homelessness, unemployment, limited education and other factors – need more practical and social support than other families and that this need can best be met through home visiting. One definition of quality in home visiting is the extent to which our home visiting programs meet or fail to address these needs.

The second set of values expresses our commitment to using data to improve quality and increase the benefits that families perceive and derive from the experience of participating in a home visiting program. We believe that every home visiting program staff member – whether an assessment worker, home visitor, supervisor, manager or other role – wants to do the best job that they can. We believe that the purpose of leadership at the state and local level is to equip, support and assist staff on the front lines to do their jobs well. We believe that the home visitors know the families, their circumstances and the challenges that families face better than anyone else involved in the program. We believe that they also understand the challenges of delivering the curriculum, supporting families and advocating on their behalf better than anyone else involved in the program. We also believe that gathering data about program operations to identify and solve problems can be an effective, efficient, supportive and instructive approach to improving the quality of home visiting.

CQI Structure. The basic structure supporting CQI is the creation of a team at the state level and a team within each program at the local level to use data to improve quality. At the state level, the Division of Community Health and Prevention already has a structure that promotes the use of data to improve quality. The Division refers to the traditional role of monitoring, technical assistance and consultation in public administration as "community support." The Division has developed policies and procedures for assessment of quality at the provider and community levels, followed by the delivery of supportive actions (through training, consultation, technical assistance, networking and other strategies) to address identified needs. This process is supported by Division management through the quarterly review of performance on a large set of metrics developed by the Division's program managers. Reports are produced at the provider and regional levels on a quarterly basis. These reports are analyzed by IDHS program staff and recommendations are forwarded to program and regional managers for discussion at a quarterly meeting. The outcome of this meeting is the formulation of a support plan, the identification of resources and the assignment of responsibility to implement the plan. Healthy Families Illinois programs are already reviewed through this process; programs supported through MIECHVP can

easily be added.. CQI data are also reviewed by the NFP NSO at the national level, and reviewed with local sites by the NSO's Nurse Consultant assigned to the site.

Thus, the core team that is supporting a local home visiting program includes staff from the Division's office of Program Planning and Development, which manages the Division's information systems and prepares the reports, the Community Support Services Consultant who is designated as the provider's primary liaison with the Division, the Bureau Chief for Child and Adolescent Health, who will be managing the local program grants made with MIECHVP funds, and a masters-prepared Maternal and Child Health Nursing Consultant who can assist the staff with questions about implementation of program models.

At the local level, home visiting program staff will be encouraged and expected to work as a team in using the data that they collect about the operation of their program to improve its quality. The team will be encouraged to meet monthly so that the use of data to understand, review and improve the quality of home visiting services becomes a routine part of program operations.

CQI Process. Implementation of the CQI process will begin with training of local project staff in the values, structure and procedure of CQI. This training may be obtained formally or provided by DCHP's regional staff.

Once the local projects have hired staff and training has been completed, the state and local project staff will meet to develop a specific CQI implementation plan for the project. This meeting will result in the establishment of priorities for data analysis (which aspects of program operation will be examined first), the data that will be collected to analyze the problem and recommended target levels. Final decisions on performance targets will be made by DCHP project managers. This process will be repeated no less than annually. Since the implementation agencies haven't been selected yet, we don't know how much experience they will have with the operation of home visiting services. If the implementation agencies are experienced, the full team will reconvene after a few CQI cycles to consider the selection of new topics. If the implementation agencies are inexperienced, the team will reconvene after a few cycles to review progress to date, determine if the performance targets were realistic, consider new targets and continue the process for more cycles. In this way, IDHS will use CQI to improve the quality of the CQI process.

Following the selection of topics and the establishment of targets, data collection will begin. This will be monitored at both the local and state levels.

The production of CQI reports will begin after a month of data collection. The initial review at both the state and local levels will not only examine performance but also consider the completeness of data collection. Reports will be distributed among the state level CQI team members for each project, all of the local projects, the members of the Executive Committee and the model developers. Data will be analyzed by program and by home visitor to promote both transparency and accountability.

The reports will be reviewed both separately and jointly by the state and local CQI teams. The joint review will include the DCHP Community Support Services Consultant or the Maternal and Child Health Nursing Consultant assigned to the project, or both. The reviewers will seek to understand the data by asking the local project staff to interpret it. Emphasis will be placed on understanding what high-performing agencies and home visitors are doing to achieve a high level of performance. This may identify best practices that can be disseminated to other MIECHVP program sites and other home visiting programs. All of the review team members will be encouraged to approach the review as an opportunity for learning, problem-solving and identifying opportunities for improvement and skill-building.

The review will culminate in an action plan. This may involve changes in procedure, changes in data collection, identification of the need for additional training or technical assistance or another strategy for improving performance. Local home visiting program staff will then implement the plan and data collection will continue. Local program staff will prepare a written summary of the interpretation and the action plan. This will be disseminated to everyone who received the performance data.

As the last step in the process, the team will reconvene to examine the data, determine if performance improved, meet with the sites to understand the data, identify any additional assistance that may be needed to improve performance, and then formulate and implement a new plan of action. This cycle will continue until the performance has improved and will begin again with the selection of a new performance topic.

Consultation with Model Developers. The Executive Committee consulted with the model developers while preparing the implementation plan to understand their approaches to monitoring and quality assurance. The models vary in the frequency and content of their monitoring and CQI activities. The NFP collects and reviews data on a monthly basis and conducts an annual review on-site. HFI performance data is already reviewed each quarter by IDHS staff and conducts an annual on-site review. Staff from the PAT state office visit new programs between three and six months after training to formulate a technical assistance plan. Consultation is then provided by telephone or electronic mail. The PAT state office also offers an on-site review of model implementation. The Director of Healthy Steps at Advocate Health Care observes service delivery, meets with the Specialists on a monthly basis and provides on-going training and technical assistance. Early Head Start programs submit monthly and semi-annual reports that are reviewed by the federal regional office. EHS sties also submit an annual self-study and participate in a triennial on-site review. The state-level team will work closely and coordinate efforts with model developers in order to complement, rather than duplicate, the monitoring, consultation, technical assistance and quality assurance activities of the national models' program offices.

Objects of CQI. Many aspects of operating a home visiting program must be examined to ensure that the program is operating with fidelity to the national model and meeting the needs of participating parents. These topics, which reflect the project's logic model, are presented below. Each topic includes a discussion of the variables that will be examined.

The Home Visitor. The qualifications, skills, training and cultural competence of the home visitor are fundamental to successful delivery of the intervention. This topic will include the home visitor's qualifications and completion of model-specific training, his or her mastery of the skills conveyed through training (including helping, teaching and advocacy skills) and cultural competence. The Illinois Birth To Three Institute has developed a framework of paraprofessional home visitor competencies which are covered through the institute's training programs. The framework will also be used to examine the home visitor's competence and identify the need for additional training. Additional consultation with the NFP NSO will occur to ensure that the nurse home visitors hired by NFP programs have the qualifications, skills, training and cultural competence require by the NSO.

The Occurrence of the Home Visit. This is the core mechanism for delivering family support, parenting education and service coordination to families. This topic includes the location of the visit (in what setting does the visit actually occur?), the timing of the visit (are visits occurring at the family's convenience?) the frequency of visits (are the occurring as often as the model prescribes?), the length of each visit, the duration of the family's participation in home visiting and the reasons for termination from services. The standards established by each model developer will be used as the basis for ensuring that families are receiving the appropriate "dosage."

The Content of the Home Visit. This is the essence of the intervention. This topic includes use of time during the visit (how is time distributed among: parent-child activities; child health, development and well-being; parent health, development, well-being, education and employment; planning; screening and other activities?). It will also include the family's perceived value of the curriculum and its cultural appropriateness. The home visit will also be used to screen families for problems such as emotional disturbance (perinatal depression), substance misuse, intimate partner violence, access to medical care, health insurance coverage and other topics). (Screening for intimate partner violence will be conducted privately to ensure that screening does not trigger additional violent behavior.) Finally, the home visit will be used to review and revise each family's individual service plan. The home visitor and the family will review referrals that have been made, those that have been completed, barriers to service access and strategies to overcome these barriers.

The Home Visitor / Family Relationship. The quality of this relationship is essential for successful service delivery. This topic will include an examination of racial, ethnic, cultural and language compatibility between the family and the home visitor, as well as the use of the Working Alliance Inventory (also used in the national cross-site evaluation of model fidelity in the "Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment" grant.

The Management of Home Visiting. This aspect of CQI will focus on the operation of the home visiting program. It will include examination of caseloads; the frequency, length and content of supervision; the recruitment, selection and retention of staff; the establishment, maintenance and effectiveness of the programs relationship with other community organizations (especially the providers of essential ancillary services); and affiliation with and accreditation by the model developer. Program operations will be compared to the model developer's standards.

Families. Several attributes of participating families will be considered in CQI. This will include an examination of recruitment (the referral sources, the number and characteristics of families referred [compared with program capacity and special capabilities] and the timing of referrals (to determine that they are being received within the time required by the model). "Special capabilities" include program characteristics such as the availability of bilingual staff. "Timing" refers to referral during the prenatal period (for models such as NFP), immediate postpartum period (for models like HFI) or later (for models such as PAT and EHS.) Finally, families' social, economic, demographic and cultural characteristics will be compared to those of the community and the target population for which the model was designed to ensure that the program is reaching its intended audience.

The Consequences of Home Visiting. The "benchmarks" discussed in Section 5 of this Implementation Plan will also be used in CQI to ensure that the program is having the effects expected from prior research on the model employed.

Universal Screening and Coordinated Intake. As this approach is developed and tested, data will also be used to determine whether all new or expectant parents in the target area have participated in the screening process, that the use of multiple home visiting programs is coordinated and that families are directed to the community services they desire, if the need for them is identified during screening and intake. This component of Illinois' MIECHVP has several aspects.

Outreach. This topic will examine the outreach activities conducted by screening agency and its relationships with the organizations that are common points of entry for families. These entry points include providers of family planning and prenatal care, hospital obstetrical units and newborn nurseries, providers of preventive health care and nutrition services (such as WIC), and other organizations that serve families with young children. These relationships are essential for ensuring that home visiting programs are supplied with an adequate number of families. Data on the number of families referred from each source, the appropriateness of these referrals and the screening agency's relationship with each agency will be examined through the CQI process. The number of new or expectant parents who are screened for services will be compared with the number of births in the target area to determine whether screening is "universal." For this part of the CQI process, the team will expand to include staff from the home visiting programs in addition to the screening agency, IDHS and other members of the Executive Committee.

Screening. This CQI topic will include the number of problems or conditions to be identified through screening, the qualifications and training of staff who are administering and interpreting screening instruments, and the number of families who are being screened and the number of families who are being identified with each of the conditions or in each of the circumstances that are the subject of screening.

Referral to Home Visiting. The initial focus of universal screening and coordinated intake will be the distribution of families among the home visiting programs in the community. This CQI topic will examine the relationship between the screening agency and each of the home visiting programs; whether each agency can identify a contact person at the other; the execution of a

Memorandum of Understanding; the number of families referred to each provider compared to the home visiting agency's capacity and specific target population; the distribution of families among home visiting programs; the number of families referred to each home visiting program who subsequently enroll in services; and the reasons that referrals are declined when families do not enroll in home visiting.

Referral for Ancillary Services. As the screening and intake system becomes established for home visiting, it will be expanded to include other community services. Similar to the variables that will be examined for referral into home visiting, this CQI topic will examine the relationships that the screening agency has with ancillary service providers; the formality of these relationships (whether each identify a regular contact person at the other agency and whether a Memorandum of Understanding been executed between the organizations) the number of families referred, the number of referrals completed and the reasons that services were declined if the family does not enroll.)

Early Childhood Network. Consultation to strengthen each community's early childhood collaboration will be tailored to each community. CQI indicators will be developed during the process of consultation and technical assistance.

Section 8: Technical Assistance Needs

The Executive Committee requests technical assistance with the following aspects of implementing the MIECHVP:

- The development of an integrated information system that supports all of the home visiting models and assistance in negotiating data sharing agreements with national model developers;

- Identifying and preparing for the implementation of significant adaptations of the national evidence-based models, such as adaptations to address the needs of families affected by emotional disturbance, substance abuse, domestic violence, parental developmental delay, homelessness or limited English proficiency;

- Designing and implementing a universal screening and coordinated intake system;

- Designing and implementing strategies to develop parent leadership in home visiting programs and community early childhood systems; and

- Establishing policy regarding the relationship between home visiting programs and the criminal justice system.

Section 9: Reporting Requirements

The Illinois Department of Human Services will comply with the legislative requirement for submission of an annual report to the Secretary regarding the activities carried out under the Maternal, Infant and Early Childhood Home Visiting program.

The report shall include the following:

- Progress on State Home Visiting Program goals and objectives
- Update on Promising Approaches
- Update on experience in Implementing Home Visiting programs in the Targeted Community(ies)
- Progress toward achievement of the Legislatively-mandated Benchmarks
- Update on the program's CQI efforts
- Update on the Administration of the Home Visiting program
- Additional Technical Assistance needs

Memorandum of Concurrence
In Support of the
Federal Maternal, Infant and Early Childhood
Home Visiting Program

This Memorandum of Concurrence ("Memorandum") relates to the new Maternal, Infant and Early Childhood Home Visiting Program ("Program") and describes the support and assistance that each participating State entity will provide, and the commitment each shall make, in support of the Program.

ARTICLE I
PARTIES

1.1 Parties and Represented Federal Programs. The Parties hereto and the Federal programs they operate which are relevant to the Program include:

(a) The Illinois Early Learning Council ("Council"), which is the State Advisory Council on Early Childhood Education and Care authorized by the Federal Head Start Act and the Home Visiting Task Force ("Task Force"), a standing committee of the Council. The Task Force's Executive Committee ("Executive Committee") includes the Task Force's co-chairs, representatives of the other Parties and other members that the Executive Committee may determine.

(b) The Governor's Office of Early Childhood Development ("OECD").

(c) The Illinois Department of Human Services ("DHS"), which includes the State's Title V, or Maternal and Child Health Services Block Grant, Program of the Social Security Act; the Single State Agency for Substance Abuse Services; the State's Child Care and Development Fund Administrator; the State's Head Start Collaboration Office; the State's Individuals with Disabilities Education Act Part C Lead Agency; the State's Mental Health Agency; the State's Temporary Assistance for Needy Families Agency; the State's Supplemental Nutrition Assistance Program Agency; and the State's Sexual Assault and Domestic Violence Prevention and Intervention programs.

(d) The Illinois State Board of Education ("ISBE"), which is the State's Elementary and Secondary Education Act Title I and State Pre-kindergarten Program Agency and the State's Individuals with Disabilities Education Act Part B Section 619 Lead Agency.

(e) The Illinois Department of Children and Family Services ("DCFS"), which is the State's Agency for Title II of the Child Abuse Prevention and Treatment Act and the State's Child Welfare Agency for Title IV-E and Title IV-B of the Social Security Act.

(f) The Illinois Department of Healthcare and Family Services ("HFS"), which is the Single State Agency responsible for the Medicaid program, including the Early and Periodic Screening, Diagnosis and Treatment Program under Title XIX of the Social Security Act and the State's Children's Health Insurance Program under Title XXI of the Social Security Act.

(g) The Illinois Coalition Against Domestic Violence ("Coalition").

1.2. Reference. The foregoing entities are referred to collectively herein as "Parties" and individually as a "Party".

ARTICLE II
DEFINITIONS

2.1. Definitions. Capitalized words and phrases used in this Memorandum have the following meanings:

"Local Home Visiting Program" means a unit of local government or a community-based not-for-profit organization which receives Program funds from DHS to operate an evidence-based home visiting program.

"Local Office" means an office of a State agency which uses State employees to provide services in the community that benefit families with young children.

"Local Service Provider" means a unit of local government or community-based not-for-profit organization which receives funds from a State agency to provide services in the community that benefit families with young children.

"Models" has the meaning set forth in Article III.

"Program" has the meaning set forth in the Preamble.

"Target Areas" has the meaning set forth in Article IV.

ARTICLE III
THE PROGRAM

3.1. Creation of the Program. The Program was created by Section 2951 of the Federal Patient Protection and Affordable Care Act ("Act"). The Act provides funds to States to support "evidence-based" models ("Models") of home visitation. The Task Force's Executive Committee has initially selected five (5) evidence-based Models for implementation in Illinois:

(a) Early Head Start Home-Based Option;

(b) Healthy Families America;

(c) Healthy Steps for Children;

(d) Nurse-Family Partnership; and

(e) Parents As Teachers.

3.2. Operation of the Program. The Models must be operated with fidelity to their original designs and must make measurable progress on four (4) of six (6) benchmarks. The six (6) benchmark areas are:

(a) Improvements in prenatal, maternal, and newborn health, including pregnancy outcomes;

(b) Improvements in child health and development, including the prevention of child injuries and maltreatment, and improvements in cognitive, language, social-emotional, and physical developmental indicators;

(c) Improvements in school-readiness and child academic achievement;

(d) Reductions in crime or domestic violence;

(e) Improvements in family economic self-sufficiency; and

(f) Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families.

3.3. Program Planning and Implementation. Planning and implementation of the Program is being led by the OECD, DHS, ISBE and the Task Force's Executive Committee.

3.4. Benchmark Measurement. Measurement of progress in each of these benchmark areas will require the collection and analysis of data for individual participants in order to measure and report progress in the aggregate among all Program participants or subgroups of Program participants.

(a) The ability of the Models to support families in each benchmark area and to collect the information needed to document progress depend upon the establishment of successful working relationships with the community-level offices and community-based organizations which deliver the other support services required by families with young children. It is also the purpose of Program funding to ensure that Local Home Visiting Programs are fully integrated into community systems for the delivery of services to families with young children.

(b) As an enhancement to Local Home Visiting Programs in the Target Areas, the Parties will support the establishment of a universal screening and coordinated intake system that would be capable of contacting every family in the Target Area, screen them for service needs and refer them to appropriate home visiting and other early childhood services.

(c) Successful implementation, operation and evaluation of the Program will require sustained collaboration between and among the Parties.

ARTICLE IV
Target Areas

4.1. Target Areas. The communities that will be targeted by the Program ("Target Areas") will be selected by the Task Force's Executive Committee.

4.2. Coordination. The Local Home Visiting Programs and the universal screening and coordinated intake system will be operated by one or more community-based organizations with financial support from DHS, which is the lead agency for Program funds and related federal grants.

ARTICLE V
Responsibilities of the Parties

5.1. Responsibilities of the Parties. The Parties will support the Program by:

(a) Supporting the implementation of universal screening and coordinated intake for home visiting and other early childhood services in the Program's Target Areas..

(b) Encouraging Local Service Providers or Local Offices to enter into written linkage agreements or memoranda of understanding with Local Home Visiting Programs to promote access to relevant services for home visiting program participants.

(c) Providing data necessary to measure relevant constructs within each of the benchmarks established in the Federal authorizing legislation.

(d) Including representatives from the Local Home Visiting Program in local initiatives to improve the coordination among providers in the Target Area who serve families with young children.

(e) Encouraging Local Service Providers to work collaboratively with the staff of a Local Home Visiting Program to enhance, develop, coordinate, promote and inform the community of services available to families with young children.

(f) Coordinating the use of other State and Federal funds which are directed for the expansion of home visiting and other early childhood services with existing Local Home Visiting Programs supported by Federal or State funds.

5.2. Progress Reports. The OECD, ISBE and DHS will inform the Task Force, the Council and the Directors of the other Parties hereto regarding the progress and operation of the Program and any additional assistance which OECD, ISBE or DHS may require in order to ensure implementation of Local Home Visiting Programs with fidelity and achievement of performance and outcome benchmarks.

ARTICLE VI
TERM AND TERMINATION

6.1. Term. This Memorandum shall commence on June 1, 2011 and, unless otherwise terminated by the Parties, shall continue through September 30, 2016.

6.2. Termination. This Memorandum may be terminated by a Party for any or no reason upon thirty (30) days' prior written notice to the other Parties. In such event, this Memorandum shall continue in full force and effect between and among the non-terminating Parties.

ARTICLE VII
MISCELLANEOUS

7.1. Renewal. This Memorandum may be renewed for additional periods by mutual consent of the Parties, expressed in writing and signed by the Parties.

7.2. Amendments. This Memorandum may be modified or amended at any time during its term by mutual consent of the Parties, expressed in writing and signed by the Parties.

7.3. Severability. If any provision of this Memorandum is declared invalid, its other provisions shall not be affected thereby.

7.4. Applicable Law and Severability. This Memorandum shall be governed in all respects by the laws of the State of Illinois. If any provision of this Memorandum shall be held or deemed to be or

shall in fact be inoperative or unenforceable as applied in any particular case in any jurisdiction or jurisdictions or in all cases because it conflicts with any other provision or provisions hereof or any constitution, statute, ordinance, rule of law or public policy, or for any reason, such circumstance shall not have the effect of rendering any other provision or provisions contained herein invalid, inoperative or unenforceable to any extent whatsoever. The invalidity of any one or more phrases, sentences, clauses, or sections contained in this Memorandum shall not affect the remaining portions of this Memorandum or any part thereof. In the event that this Memorandum is determined to be invalid by a court of competent jurisdiction, it shall be terminated immediately.

7.5. Records Retention. The Parties shall maintain for a minimum of five (5) years from the later of the date of final payment under this Memorandum, or the expiration of this Memorandum, adequate books, records and supporting documents to comply with 89 Ill. Adm. Code 509. If an audit, litigation or other action involving the records is begun before the end of the five-year period, the records shall be retained until all issues arising out of the action are resolved.

7.6. No Personal Liability. No member, official, director, employee or agent of any Party hereto shall be individually or personally liable in connection with this Memorandum.

7.7. Assignment; Binding Effect. This Memorandum, or any portion thereof, shall not be assigned by any of the Parties without the prior written consent of the other Parties. This Memorandum shall inure to the benefit of and shall be binding upon the Parties and their respective successors and permitted assigns.

7.8. Precedence. In the event there is a conflict between this Memorandum and any of the exhibits hereto, this Memorandum shall control. In the event there is a conflict between this Memorandum and relevant statute(s) or Administrative Rule(s), the relevant statute(s) or rule(s) shall control.

7.9. Notices. All written notices, requests and communications may be made by electronic mail to the e-mail addresses set forth below.

To the Council:

Julie Smith
Co-Chair, Illinois Early Learning Council
100 West Randolph Street
Chicago, Illinois 60601
Julie.Smith@illinois.gov

Harriet Meyer
Co-Chair, Illinois Early Learning Council
c/o The Ounce of Prevention Fund, Inc.
33 West Monroe Street, Suite 2400
Chicago, Illinois 60603
HMeyer@OunceofPrevention.org

To OECD:

Shannon Christian
Director
Governor's Office of Early Childhood Development
100 West Randolph Street
Chicago, Illinois 60601
Shannon.Christian@illinois.gov

To DHS

Michelle R. B. Saddler
Secretary
Illinois Department of Human Services
100 South Grand Avenue East, 3rd Floor
Springfield, Illinois 62762
Michelle.Saddler@illinois.gov

To ISBE:

Christopher Koch
Superintendent
Illinois State Board of Education
100 West Randolph Street, Suite 14-300
Chicago, Illinois 60601
Chris.Koch@isbe.net

To DCFS:

Erwin McEwen
Director
Illinois Department of Children and Family Services
100 West Randolph Street
Chicago, Illinois 60601
Erwin.McEwen@illinois.gov

To HFS:

Julie Hamos
Director
Illinois Department of Healthcare and Family Services
401 South Clinton Street, 7th Floor
Chicago, Illinois 60607
Julie.Hamos@illinois.gov

To the Coalition:

Vickie Smith
Executive Director
Illinois Coalition Against Domestic Violence
801 South 11th Street
Springfield, IL. 62703
Vsmith@ilcadv.org

7.10. Entire Agreement. The Parties understand and agree that this Memorandum constitutes the entire agreement between the Parties; no promises, terms, or conditions not recited, incorporated or referenced herein, including prior agreements or oral discussions, shall be binding upon either Party.

7.11. Availability of Appropriations. Pursuant to 30 ILCS 500/20-60, the Parties' respective obligations hereunder shall cease immediately, without penalty, if: (a) the Illinois General Assembly fails to make an appropriation sufficient to pay such obligations; (b) adequate funds are not appropriated or granted to the respective Parties by the Illinois General Assembly to allow the respective Parties to fulfill their obligations under this Memorandum; or (c) funds appropriated are de-appropriated or not allocated.

7.12. Counterparts. This Memorandum may be executed in one or more counterparts, each of which shall be considered to be one and the same agreement, binding on all Parties hereto, notwithstanding that all Parties are not signatories to the same counterpart.

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In witness whereof, the Parties hereto have caused this Memorandum to be executed by their duly authorized representatives.

Julie Smith — 1-2-11
Julie Smith — Date
Deputy Chief of Staff, Office of the Governor
Co-Chair, Early Learning Council

Harriet Meyer — Date
Director, Strategic Initiatives for the Ounce of Prevention Fund
Co-Chair, Early Learning Council

Shannon Christian — Date
Director, Governor's Office of Early Childhood Development

Michelle R. B. Saddler — Date
Secretary, Illinois Department of Human Services

Christopher Koch — Date
Superintendent, Illinois State Board of Education

Erwin McEwen — Date
Director, Illinois Department of Children and Family Services

Julie Hamos — Date
Director, Illinois Department of Healthcare and Family Services

Vickie Smith — Date
Executive Director, Illinois Coalition Against Domestic Violence

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Julie Smith
Deputy Chief of Staff, Office of the Governor
Co-Chair, Early Learning Council

Date

Harriet Meyer
Director, Strategic Initiatives for the Ounce of Prevention Fund
Co-Chair, Early Learning Council

June 1, 2011
Date

Shannon Christian
Director, Governor's Office of Early Childhood Development

May 27, 2011
Date

Michelle R. B. Saddler
Secretary, Illinois Department of Human Services

Date

Christopher Koch
Superintendent, Illinois State Board of Education

Date

Erwin McEwen
Director, Illinois Department of Children and Family Services

May 27, 2011
Date

Julie Hamos
Director, Illinois Department of Healthcare and Family Services

Date

Vickie Smith
Executive Director, Illinois Coalition Against Domestic Violence

Date

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Co-Chair, Early Learning Council

Shannon Christian — Date
Director, Governor's Office of Early Childhood Development

Michelle R. B. Saddler — 5/25/11
Michelle R. B. Saddler — Date
Secretary, Illinois Department of Human Services

Christopher Koch — Date
Superintendent, Illinois State Board of Education

Erwin McEwen — Date
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Shannon Christian — Date
Director, Governor's Office of Early Childhood Development

Michelle R. B. Saddler — Date
Secretary, Illinois Department of Human Services

Christopher Koch — 6-1-11
Date
Superintendent, Illinois State Board of Education

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Julie Hamos — Date
Director, Illinois Department of Healthcare and Family Services

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Director, Governor's Office of Early Childhood Development

Michelle R. B. Saddler — Date
Secretary, Illinois Department of Human Services

Christopher Koch — Date
Superintendent, Illinois State Board of Education

Erwin McEwen — Date
Director, Illinois Department of Children and Family Services

Julie Hamos — 5/27/11
Julie Hamos — Date
Director, Illinois Department of Healthcare and Family Services

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Executive Director, Illinois Coalition Against Domestic Violence

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Shannon Christian — Date
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Michelle R. B. Saddler — Date
Secretary, Illinois Department of Human Services

Christopher Koch — Date
Superintendent, Illinois State Board of Education

Erwin McEwen — Date
Director, Illinois Department of Children and Family Services

Julie Hamos — Date
Director, Illinois Department of Healthcare and Family Services

Vickie Smith — 5/27/11 Date
Executive Director, Illinois Coalition Against Domestic Violence

Illinois Department of Human Services
Division of Community Health and Prevention
Strong Foundations Partnership
FFY'10 Narrative Budget Justification
Revised for the MIECHVP Implementation Plan
June 8, 2011

Note: The narrative budget justification discusses each Object Class Category found on the SF424A. This budget has been revised in response to the needs assessment for the implementation plan.

Personnel $146,840

One Advanced Accountant at IDHS to account for these and other home visiting and maternal and child health program funds. Salary based on current midpoint for payroll title. Full time for 12 months.

One Public Services Administrator Option 6 to monitor the collection, perform the analysis and prepare reports for MIECHVP. Salary based on current midpoint for payroll title. Full time for 12 months.

Fringe Benefits $93,230

Includes Social Security (7.65% of salary), Retirement (34.19% of salary) and Group Health Insurance ($15,900 per FTE per year).

Travel $0

Equipment $0

Supplies $10,089

(Office Supplies, $740; office furniture, $3,000; PC Workstation, $2,000; printing, $2,000; postage, $2,349)

Construction $0

Contractual $2,974,870

1) MIS Charges for IDHS personnel $6,120

2) Governor's Office of Early Childhood Development $357,820

1 FTE Senior Public Service Administrator (Project Director), $88,770;1 FTE Public Service Administrator, (Evaluation Coordinator) $83,300; Fringe Benefits, $97,020; Travel, $9,430 (out-of-state, $6,670; in-state,

$2,760); Supplies, $6,740; Other (telecom) $4,210; Indirect (25.4% of salary & fringe), $68,350. Funds to be transferred by Interagency Agreement.

3) Strong Foundations $673,230

"Set-aside" to continue the "Supporting Evidence-Based Home Visiting Programs to Prevent Child Maltreatment" grant from the USDHHS Administration for Children and Families. Detailed budget to be provided to USDHHS/ACF.

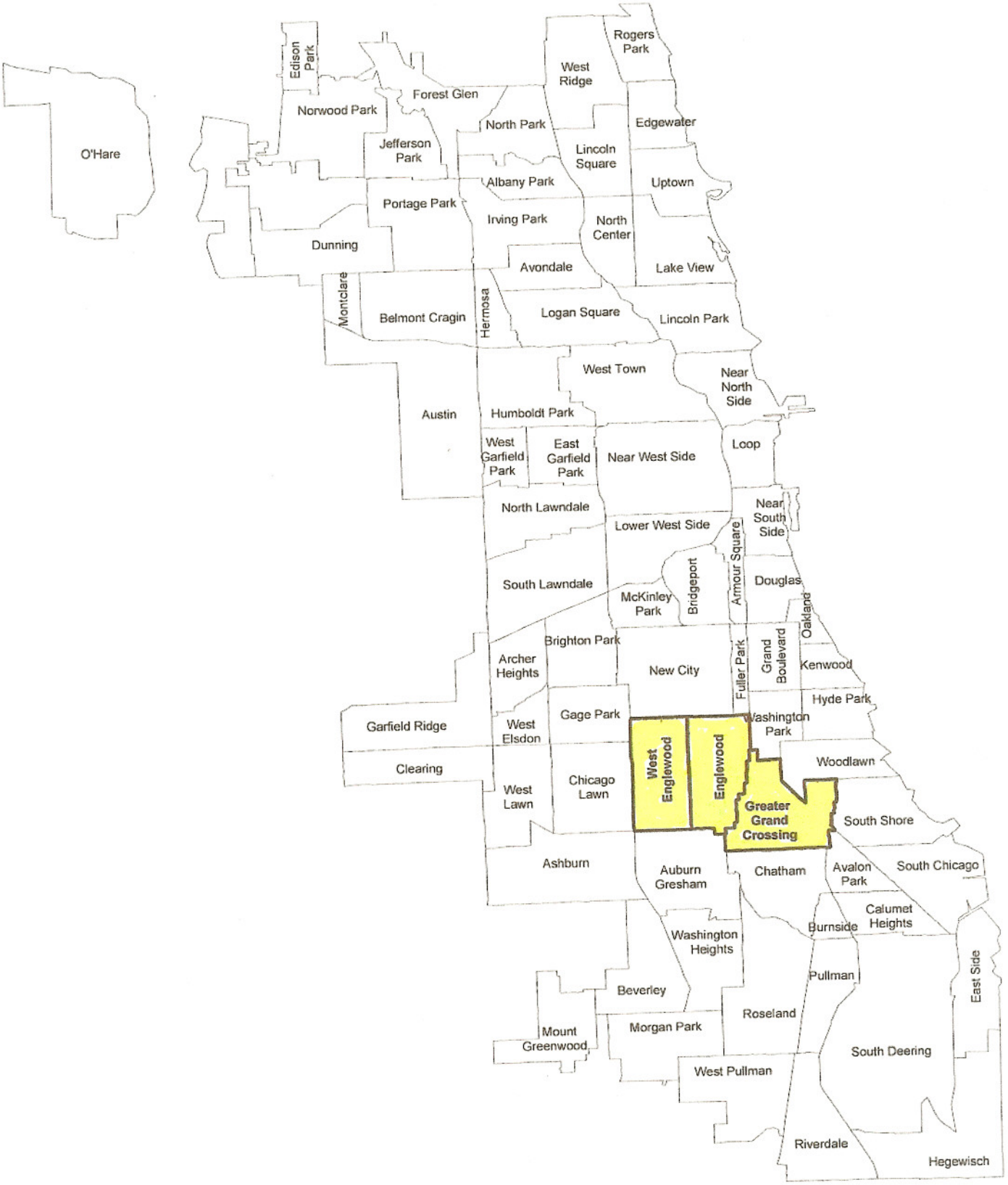
4) Training of Local Home Visiting Program Staff in Selected Model	$82,500
5) Needs Assessment: Chapin Hall, University of Chicago	$90,000
6) Data Collection (administration of standardized questionnaires)	$113,750
7) Training of Local Home Visiting Program Staff on "Strengthening Families" Risk and Protective Factors	$41,250
8) Training of Local Home Visiting Program Staff on Trauma-Informed Practice	$45,200
7) Consultation on High-Risk Families	$30,000
8) Training of Local Home Visiting Program Staff on Special Need Families	$35,000
9) Program Expansion (both new and existing)	$1,500,000

Other (Telecommunication)	$4,110
Total Direct Costs	$3,229,139
Indirect Costs	$60,980

The Illinois Department of Human Services (IDHS) is required by Circular A-87 to have a Public Assistance Cost Allocation Plan (PACAP). IDHS also submits a Departmental Indirect Cost Allocation Plan (DICAP) for indirect costs to the U.S. DHSS, Division of Cost Allocation for review and approval. DICAP expenditures are allocated quarterly in accordance with the PACAP. IDHS does not use indirect rates for the U.S. DHHS programs. The rate presented in the grant budget is based on actual expenditures and the ratio of indirect and direct costs resulting from the Public Assistance Cost Allocation Plan methodologies. The rate is only used for budgeting purposes.

Grand Total	$3,290,119

MIECHVP NEEDS ASSESSMENT



MIECHVP Needs Assessment
ChicCAs PSS-mfm 5-26-11

MEICHVP NEEDS ASSESSMENT

MEICHVP Needs Assessment
Statewide-Macon County
PSS-mfm 5-26-11

Illinois Department of Human Services
X02MC19400

MIECHVP NEEDS ASSESSMENT

MEICHVP Needs Assessment
Elgin PSS-mfm 5-26-11

Curriculum Vitae

Teresa Kelly, LCSW, ACSW, QCSW, C-ACYFSW

Children's Home + Aid
Mid-Central Region
403 South State Street
Bloomington, IL 61701
309-834-5277 / cell-309-530-2550
tkelly@childrenshomeandaid.org

Professional Profile

- Professional concentration in children and families and the development of evidence based programs for at-risk children that address: infant mental health, prevention, and early intervention with a focus on children birth to six years of age
- Specializing in the organization, planning, execution, integration and evaluation of multiple programs providing home visiting, prevention and early intervention services
- Primary administrator over multi-agency partnership providing Healthy Families Illinois home visiting, doula, and infant mental health services
- Supervise and administrate multiple grant-based prevention, early intervention programs
- Developed a coordinated system for collecting data, monitoring, and evaluating programs
- Participation in statewide, regional, and local home visiting, prevention and early intervention committees
- Developed a multi-disciplinary coalition to integrate infant mental health , home visiting, and child protection community services
- Focus on the practice of evidence based home visiting programs and the effect on the young child, parent /child bonding, and child development
- Initiated and developed a working partnership between the Judiciary, legal community, and social services to strengthen services to Family Court
- Extensive professional collaborations for the improvement of services to children ages birth to 6 years.
- Oversee planning, implementation, and evaluation of grants
- Responsible for regular reporting to private, state, and federal funding agencies; fiscal and narrative reporting
- Over 30 years professional experience focusing on early intervention, infant mental health, domestic violence, and child trauma to culturally diverse populations, rural and urban areas.

Education

Master of Social Work, Child and Family Concentration, Illinois State University, Normal, IL. May 2004
Research Project: "Does the use of Family Visitation Centers Increase Victim's Feelings of Safety and Well-Being When There is Court Ordered Non-Custodial (Batterer) Parent / Child Visitation?"

Bachelor of Science, Human Resources and Family Studies, University of Illinois, Urbana, IL. May 1978. Practicum in battered women's shelter and hospital pediatrics ward.

Research Experience

Supervised Family Visitation and Exchange Center, Children's Home + Aid Society of Illinois, Bloomington, IL 11/2004 to May 2005
"Is there a Relationship Between the Use of the Family Visitation Center and the Reduction of Stress for Parents in High Conflict Divorce and / or Domestic Violence
Masters Research, Illinois State University, Normal, IL, 10/2003 to May 2004
Developed data collection tool, collected, maintained, and statistically evaluated data for continuing study on the impact of the use of a family visitation center on a victim's feelings of safety and well-being when there is court ordered contact with the batterer due to non-custodial parent/child visitation.

Committees and Appointments

- Early Learning Council Home Visiting sub-committee Research and Evaluation workgroup
- Early Learning Council Home Visiting sub-committee Innovative Strategies workgroup
- Home Visiting subcommittee of the Early Learning Council
- Healthy Families Illinois System-Wide Logic Model and Evaluation Committee
- Illinois State Bar Association Task Force for Children's Waiting Rooms in the Courts
- Illinois Family Violence Coordinating Councils Visitation Exchange Advisory Committee
- McLean County Domestic Violence Task Force
- Illinois Family Violence Prevention Council Court Structure Committee
- McLean County Domestic Violence Task Force Youth and Children Work Group
- Standardization Committee for National Family Visitation Center Guidelines
- Corporate Alliance to End Partner Violence Regional Committee
- Crisis Nursery Coalition of Illinois
- Healthy Families Illinois Public Awareness Statewide Committee
- Healthy Families Illinois Program/ Evaluation/ Training Statewide Committee
- Healthy Families Illinois Payment Structure Committee
- Strengthening Families Illinois Building Resiliency Committee
- Children's Mental Health Act Statewide Task Force
- Children's Mental Health Act Policy and Resource Subcommittee
- Birth to Five Social / Emotional Statewide Committee
- Birth to Five State Workgroup
- Birth to Five Systems Coordination State Workgroup
- Unmet Needs Project Statewide Workgroup

Certifications and Licensures

Qualified Clinical Social Worker (2010)
Certified Advanced Children, Youth, and Family Social Worker (2010)
Academy of Certified Social Workers (2008)
Licensed Clinical Social Worker, State of Illinois, License #: 1490011650

Certified Danger Assessment Screener by Dr. Jacquelyn Campbell (2007)
Child Welfare License (1996)
Child Endangerment and Risk Assessment Protocol Assessment Certification (1987, 1996)

Professional recognition

- Soroptimist Ruby Award Winner (2010)
- Philip Covey Memorial Award of Excellence presented by United Way of McLean County for The Children's Room (2009)
- Women of Distinction nominee presented by the YWCA McLean County (2009)
- Recipient of the Public Citizen Award presented by the McLean County Bar Association in recognition of dedicated service in the preservation of the history of the legal system in McLean County as Program Director for the following programs: The McLean County Family Visitation Center, Kids' Turn Divorce Education for Children and Their Parents, and The Children's Room at the Law and Justice Center. (2008)
- Prevent Child Abuse Illinois Program of Excellence Award as Program Director for the Healthy Start Healthy Families Illinois Program (2007)
- Prevent Child Abuse Illinois Program of Excellence Award as Program Director for the Mclean County Family Visitation Center (2005)
- Nominated for Prevent Child Abuse Illinois Blue Ribbon Program Excellence Award as Program Director for the McLean County Family Visitation Center (2004)
- Nominated for Prevent Child Abuse Illinois Blue Ribbon Program Excellence Award as Program Director for Family Systems Support Program (2004)
- Recognition and Commendation for Outstanding Professionalism in a Sexual Assault Investigation (1989)

Professional experiences

Director, Family Support Services, The Children's Foundation, mid-central region of Children's Home + Aid.
Administrate and supervise programs: Healthy Start (Healthy Families Illinois program), Doula program, Infant Mental Health Partnership Grant, Early Start, Crisis Nursery, Family Visitation Center, Family Solutions, Extended Family Support, , The Children's Room at the Law and Justice Center, Kids' Turn Parent Divorce Education Program, Educational Advocacy Program, The Butterfly Project an Illinois Violence Prevention Safe From the Start program, Parents Care + Share
November 2000 to present

- Development, management, and evaluation of agency's infant mental health / child trauma / domestic violence / family preservation / prevention and early intervention programs and group services to high risk, multi-issue families
- Lead Agency Director for Healthy Families Illinois program multi agency collaboration
- Program quality assurance
- Fiscal oversight of managed programs
- Grant writer
- Development and management of multi-agency collaborative advisory boards
- Ensure domestic violence protocol

- Oversight of family preservation program that provides intensive intervention services for families in crisis with: domestic violence, child abuse, sexual abuse, substance abuse, and mental illness
- Oversight of the Crisis Nursery, a program that provides family enhancement services and shelter for children ages 0-6 years when families are experiencing: domestic violence, child abuse, homelessness, substance abuse, or crisis
- Ensure compliance of programs with the following protocols:
    - Domestic violence/victim services
    - Healthy Families Illinois
    - Health Family America Credentialing
    - Department of Children and Family Services
    - Council of Accreditation
    - Best Practice
- Complete quarterly and annual reports for all program funding sources (fiscal and narrative)
- Select, supervise, train, and evaluate all staff and interns in Family Support Services Programs
- Provide training to staff on infant mental health and child trauma, domestic violence, child abuse, mental health issues, and documentation
- Speak on behalf of Mid-Central's Family Support Services Programs on the local and state level
- Oversight and Lead Facilitator for Divorce Education Workshops for families involved in high conflict divorce

Acting Public Administrator, Department of Children and Family Services
January 2000 to May 2000

- Supervised a team of team of eight Child Welfare Specialist II in McLean and Dewitt Counties
- Oversight of day-to-day operations of services to families to assist in cases of domestic violence, child abuse and neglect, sexual abuse, and substance abuse.
- Coordinated foster placements and services to children and foster families as well as reunification services
- Implemented, wrote, and coordinated Wrap plans to support placement of children with their family.
- Supervised Family First, a high-risk family preservation program, as well as concrete needs programs: Housing Advocacy, Enhancement, and Norman funding.
- Supported and advised casework staff, enhanced communication and case hand-off between investigations and casework staff
- Acted as liaison between agency and judiciary and State's Attorney's Office

Program Monitor / Child Protection Investigator / Child Welfare Specialist II,
Department of Children and Family Services
March 1981 to May 1990; May 1996 to November 2000

- Supervised high risk family preservation program
- Completed child abuse and neglect investigations in Champaign, Piatt, Ford, DeWitt, McLean, and Livingston counties

- Provided child welfare services covering the four domains of: domestic violence, child abuse, sexual abuse, substance abuse, and mental illness in Champaign, Piatt, Ford, DeWitt, McLean, and Livingston counties
- Prepared case for court intervention
- Provided court testimony

MARC Center 0 to 3 years Program Coordinator / School Caseworker, MARC Center
July 1978 to March 1981

- Coordinated and implemented first infant stimulation group for children ages 0 to 3 years at MARC Center
- Coordinated children's medical and educational needs
- Developed and implemented early intervention stimulation programs
- Assisted in mainstreaming students with special needs
- Arranged and coordinated services from Division of Crippled Children, Social Security Disability, Easter Seals, and Shriner's Hospital.

Training Experience

Developed and presented Seminars in:

- Maternal Depression and Mental Health Issues in Home Visiting
- Home Visiting: How to Ask the Difficult Questions and Why this is Important
- Professional Documentation
- Multi-Disciplinary Systems Coordination
- McLean County Family Visitation Center Use and Therapeutic Approach
- Family Law Division of the McLean County Bar Association Collaboration with the Family Visitation Center
- Victim's Rights versus Children's Rights-Where Is The Line Drawn
- Identifying Child Abuse and Neglect
- Mandated Reporter Training
- Understanding the Dynamics of Domestic Violence
- Advocacy for Women Who Do Not Leave Abusive Relationships
- Safety Planning

Lead Presenter "Effects of Supervised Visitation on Victims and Their Co-Parent Relationship"
National Institute for Safe Havens Grantees: Emerging Ideas: A Critical Dialogue
Baltimore, Maryland March 2005

Co-Presenter for Praxis International National Visitation Conference on Collaborations with Batterers' Treatment Programs June 2006.

Organization Associations

National Association of Social Workers
Supervised Visitation Network

Greenpeace

Residences

1117 East Monroe Street
Bloomington, Illinois 61701

222 North Columbus, #408
Chicago, Illinois 60601

Governor's Office of Early Childhood Development
Position Description
Strong Foundations Partnership Project Director

Working under the general supervision of the Director of the Governor's Office of Early Childhood Development, the Strong Foundations Partnership Project Director coordinates the day-to-day program implementation Specific responsibilities include:

1. Organizes, plans, executes, controls and evaluates the operation of the Strong Foundations Partnership. Plans for the effective and efficient utilization of program resources and organizes activities to ensure that the goals and objectives of the Strong Foundations Partnership are achieved. Confers with management on the integration of program functions and activities to resolve administrative problems and improve program operations. Establishes priorities among assignments, establishes times of completion and sets the quantity and quality of work products and services; monitors output in order to ensure adequate work flow; identifies and discusses program projects, problems and issues.

2. Works closely with the co-chairs, committee chairs and members of the Early Learning Council's Home Visiting Task Force in the design, implementation and evaluation of the Strong Foundations Partnership.

3. Works closely with agency directors and program staff to coordinate the activities of home visiting programs in the Illinois Department of Human Services, the Illinois State Board of Education and the Illinois Department of Children and Family Services.

4. Serves as the Project Director for the Strong Foundations project, supported by the "Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment" from the U.S. Administration for Children and Families, supervises the program coordinator and oversees the planning, implementation and evaluation of grant activities.

5. Develops and maintains ongoing communications with the federal Health Resources and Services Administration, the federal Administration for Children and Families, national organizations conducting program evaluations and other state home visiting project directors., as well as other private and public organizations and interest groups.

6. Supervises the Strong Foundations Partnership Evaluation Coordinator.

7. Performs other duties as required or assigned which are reasonably within the scope of the duties enumerated above.

REQUIREMENTS:

Requires knowledge, skill and mental development equivalent to completion of four years of college, preferably with courses in social work or early childhood development, business or public administration. Requires prior experience equivalent to three years of progressively responsible administrative experience in a health or human services organization.

Illinois Department of Human Services
Position Description
Strong Foundations Partnership Evaluation Coordinator

Working under the general supervision of the Strong Foundations Partnership Project Director in the Governor's Office of Early Childhood Development, the Strong Foundations Partnership Evaluation Coordinator works with the Early Learning Council, the Council's Home Visiting Task Force, and relevant state agencies and contractors in the design, implementation and review of projects to evaluate the effectiveness and performance of home visitation programs and home visitation program infrastructure. Works closely with institutions of higher education and contractors to direct the evaluation of home visitation programs; directs the implementation of changes in project evaluation design desired by the Office of Early Childhood Development and the Home Visiting Task Force. Specifically:

1. Plans, designs and oversees complex research regarding the performance and effectiveness of home visitation programs to set and evaluate progress toward benchmark indicators of health, social, behavioral and economic status established by the U.S. Health Services and Resources Administration and the Administration of Children and Families for the Strong Foundations Partnership project.

2. Plans, designs and oversees complex research regarding the performance and effectiveness of home visitation programs to determine their impact on the health, social and economic systems of various communities; develops strategies and option s to deal with problems of research and evaluation design, measurement, data collection and analysis; monitors, evaluation activities and critically reviews implications of findings; analyses results of research studies to provide a basis for management decision concerning programs, policy and budget projections.

3. Provides consultative assistance to the Office of Early Childhood Development, the Home Visiting Task Force, relevant state agencies and contractors in the formulation of home visiting program policy and the design and implementation of management information systems. Conducts research and develops proposals, position papers and other documentation to support policy revisions and changes.

4. Performs other duties as required or assigned that are reasonable within the scope of the duties and responsibilities enumerated above.

Requires knowledge, skill and mental development equivalent to completion of four years of college and a Master's degree in Economics, Epidemiology, Program Evaluation or a closely related field. Requires four years of professional experience in the field of research and or education in program evaluation. Requires thorough knowledge of measurement, techniques, sources and data. Requires thorough knowledge of research and statistical methods and techniques and methods of presentation. Requires thorough knowledge of current research in the field of home visitation. Requires extensive knowledge of state and federal objectives policies, programs and services regarding home visiting.

Illinois Department of Human Services
Position Description
Strong Foundations Partnership Fiscal Coordinator

Working under the general supervision of the Chief of the Bureau of Fiscal Support Services in the Division of Community Health and Prevention, the Strong Foundations Partnership Fiscal Coordinator works with other Bureau staff to maintain complex accounting subsystems involving the maintenance of ledger accounts for home visiting and other maternal and child health programs administered by the Division of Community Health and Prevention; establishes the general account book format for use by Bureau staff, develops procedures for the efficient operation of the Bureau; analyzes program accounting reports; analyses line-item obligation and expenditure patterns to maintain budgetary control in accordance with the operational requirements of the annual appropriations for the Division of Community Health and Prevention; provides data and fiscal information to assist in the formulation of the operations section of the annual budget request; assists in developing the budget sections for federal and other grant applications; serves as assistant to the Bureau Chief; acts for the Bureau Chief in budget, fiscal and accounting matters in the absence of the Bureau Chief. Specifically:

1. Analyzes and reviews vouchers within the Consolidated Accounting and Reporting System (CARS) accounting system; authorizes approval of vouchers at the second level within the CARS accounting system to forward to the Office of Fiscal Services for payment; functions as the Division liaison to the Office of Fiscal Services.

2. Designs and implements specific Crystal reports to extract desired fiscal data from CARS accounting system; responds to Division and Department requests for data.

3. Manages the reconciliation of Division accounting records to the CARS accounting system; ensures that all discrepancies are reconciled and appropriate corrections or adjustments are entered into CARS.

4. Develops day-to-day accounting policy and procedures for the accounting staff within the Bureau, ensures timely and accurate processing of time-sensitive payment to vendors and grant program providers.

5. Identifies federal cash needs for payments in process, provides information for weekly federal cash draws for various awards to the Office of Fiscal Services staff in a timely manner.

6. Performs other duties as required or assigned which are reasonably within the scopy of the duties enumerated above

Requires knowledge, skill and mental development equivalent to completion of four years of college. Requires three years of administrative experience in business administration, public or private accounting or auditing. Requires a thorough knowledge of the principles of accounting and laws, rules and regulations relating to accounting systems and procedures, particularly the Comptroller's Uniform Statewide Accounting System (CUSAS) and federal regulations regarding grants administration. Requires working knowledge of the principles of governmental accounting, program budgeting , personnel, statistics and procurement.

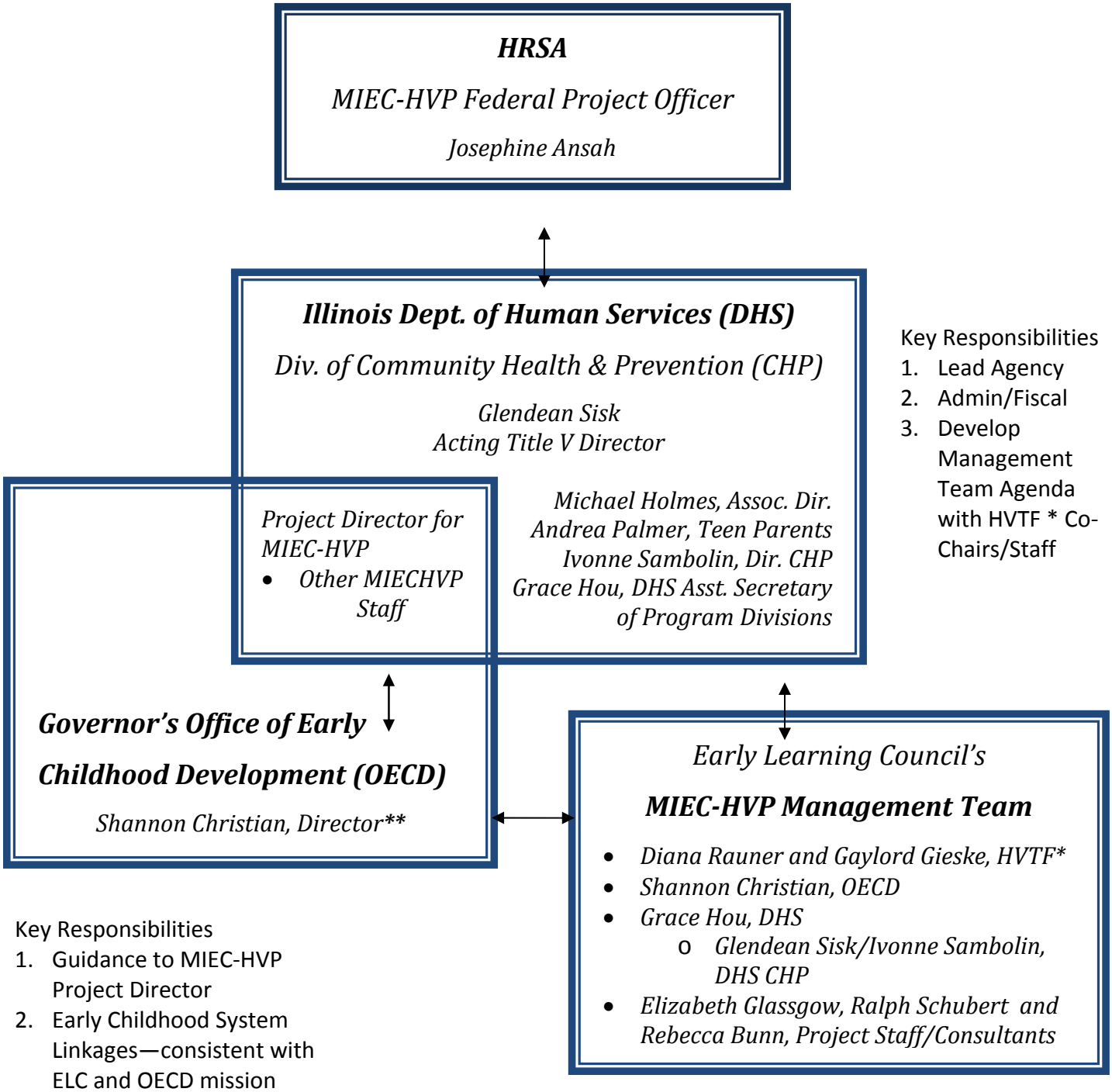
Position Description
MIECHVP Data Manager

Under the direction of the Manager, Data Unit, Office of Program Planning and Development, designs and conducts complex analyses of public health data using commercial relational database packages, the Cornerstone Management Information System and other appropriate software. Extracts and manipulates data from established information systems to match and combine records for participants in various programs.

1. Achieves and maintains proficiency in the use of the commercial relational database package or other reporting system selected for the Maternal, Infant and Early Childhood Home Visiting Program.
2. Trains and assists staff from IDHS, other state agencies and organizations and local service providers in the use of the MIECHVP reporting software.
3. Monitors the submission of data by MIECHVP grantees for timeliness, completeness and internal consistency; works through other IDHS staff to address problems in data collection and reporting.
4. Extracts data from the Illinois Department of Healthcare and Family Services' Medical Data Warehouse, the Illinois Department of Children and Family Services Statewide Automated Child Welfare Information System, the Cornerstone Management Information System, data files received from other national home visiting program developers, and other maternal and child health databases in order to compile all of the data required for MIECHVP reporting.
5. Plans and conducts sophisticated statistical and epidemiological analyses that fulfill the unit's evaluation and performance management responsibilities for the MIECHVP. These analyses will examine key aspects of local program performance for continuous quality improvement as well as reporting on progress toward outcome constructs and benchmarks specified by the federal government.
6. Produces a variety of reports and visual presentations of data using geographic information system (GIS) software and related software packages. This process will involve extraction of data elements from databases and manipulation into appropriate formats.
7. Handles requests for specific types of maternal and child health data from both internal and external sources.
8. Performs other duties as required or assigned which are reasonably within the scope of the duties enumerated above.

Requires knowledge, skill and mental development equivalent to completion of four years of college, with courses in electronic data processing, statistics, epidemiology, or public administration. Requires three years professional experience in data analysis and report writing as well as knowledge of research principles. Requires extensive training and experience in word processing software, graphics software, geographic information software and spreadsheet/database software. Other desirable software training includes searching mainframe-archived files and transferring files from a mainframe to a local computer drive. Requires extensive training and experience in large scale statewide integrated management information systems (preferably involving maternal and child health programs, extraction of data from data systems using appropriate SQL software, database design and designing process to promote program integrity and quality.

Organizational Chart
Illinois' Maternal, Infant and Early Childhood Home Visiting Project



Key Responsibilities
1. Lead Agency
2. Admin/Fiscal
3. Develop Management Team Agenda with HVTF * Co-Chairs/Staff

Key Responsibilities
1. Guidance to MIEC-HVP Project Director
2. Early Childhood System Linkages—consistent with ELC and OECD mission

Key Responsibilities
1. Coordination of Players
2. Input from HV Stakeholders
3. Convening, Policy Setting, & Decision Making

**Diana Rauner and Gaylord Gieske co-chair the Home Visiting Task Force (HVTF), which includes representatives from the Dept. of Human Services, the Dept. of Healthcare and Family Services, the Dept. of Children and Family Services, and the State Board of Education, along with advocacy organizations, parents, and other stakeholders. The HVTF is part of the state's Early Learning Council.*
***OECD Reports to Julie Smith, Deputy Chief of Staff to the Governor and Early Learning Council Co-Chair.*

LOGIC MODEL FOR ILLINOIS' MATERNAL, INFANT AND EARLY CHILDHOOD HOME VISITING PROGRAM - THE STRONG FOUNDATIONS PARTNERSHIP

THE PLANNED WORK		THE INTENDED RESULTS		
Inputs	Activities	Outputs	Outcomes	Impact
Staff	Recruit and hire staff per model specifications	Timing of home visit initiation	Increased utilization of prenatal care	Improved maternal and newborn health
Training Institute	Home visitors complete core training per model specifications	Number of home visits attempted	Decreased use of alcohol, tobacco and other drugs	
	Home visitors complete supplemental training per model specifications	Number of home visits completed	Regular use of contraception	
	---	Length of each visit	increased intrapartum interval	
Families	Conduct outreach activities	Content of each home visit	Increased screening for maternal depression	
	Screen families for eligibility	Retention in home visiting	Increased duration of breastfeeding	
MIECHVP and other grant funds	Offer home visiting services	Quality of relationship between home visitor and family	Increased use of well-child care	
	Conduct home visits per model specifications	---	Increased health insurance coverage	
	Provide reflective supervision per model specifications	Assessment for additional service needs	Decreased use of the emergency department for non-emergency care	Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits
	Conduct group meetings per model specifications	Referral for needed services	Increased provision of information on the prevention of childhood injuries	
	---	Advocacy on behalf of families for needed services	Reduced rate of injuries requiring medical treatment	
Other early childhood service providers in the community	Establish relationships with other community agencies serving expectant families and families with young children	Follow up with families and service providers to confirm completion of referrals	Decreased reports of suspected maltreatment	
	Participate in community early childhood collaboration	---	Decreased rate of confirmed maltreatment	
	Participate in MIECHVP learning community	Comparison of the population served to the population targeted	Decreased rate of first-time occurrence of maltreatment	
	---		Increased parental knowledge of child development	Improvement in school readiness and achievement
	Participate in the development and testing of a system of universal screening and coordinated intake for the community early childhood service delivery system		Improved parent-child interaction Decreased use of harsh discipline Decreased level of parental stress Normal child development Normal development of general cognitive skills Normal development of a positive approach to learning Normal social behavior, emotional regulation and emotional well-being Normal height and weight	

Model developers and funding agencies	Collect and submit data for MIECHVP-funded families			
	Conduct Continuous Quality Improvement data reviews			

LOGIC MODEL FOR ILLINOIS' MATERNAL, INFANT AND EARLY CHILDHOOD HOME VISITING PROGRAM - THE STRONG FOUNDATIONS PARTNERSHIP

THE PLANNED WORK		THE INTENDED RESULTS		
Inputs	Activities	Outputs	Outcomes	Impact
	Collaborate with model developers and funding agencies to review and improve the quality of services Complete program affiliation and recognition per model requirements		Increased screening for domestic violence Increased referral of those at risk for domestic violence services Development of a personal safety plan	Reduction in domestic violence
			Increased household income and benefits Increased employment or education Increased health insurance coverage	Improvements in family economic self-sufficiency
			Increased assessment for service needs Increased referrals for services to address identified needs Increased completion of referrals	Improvements in the coordination and referrals for other community resources and supports